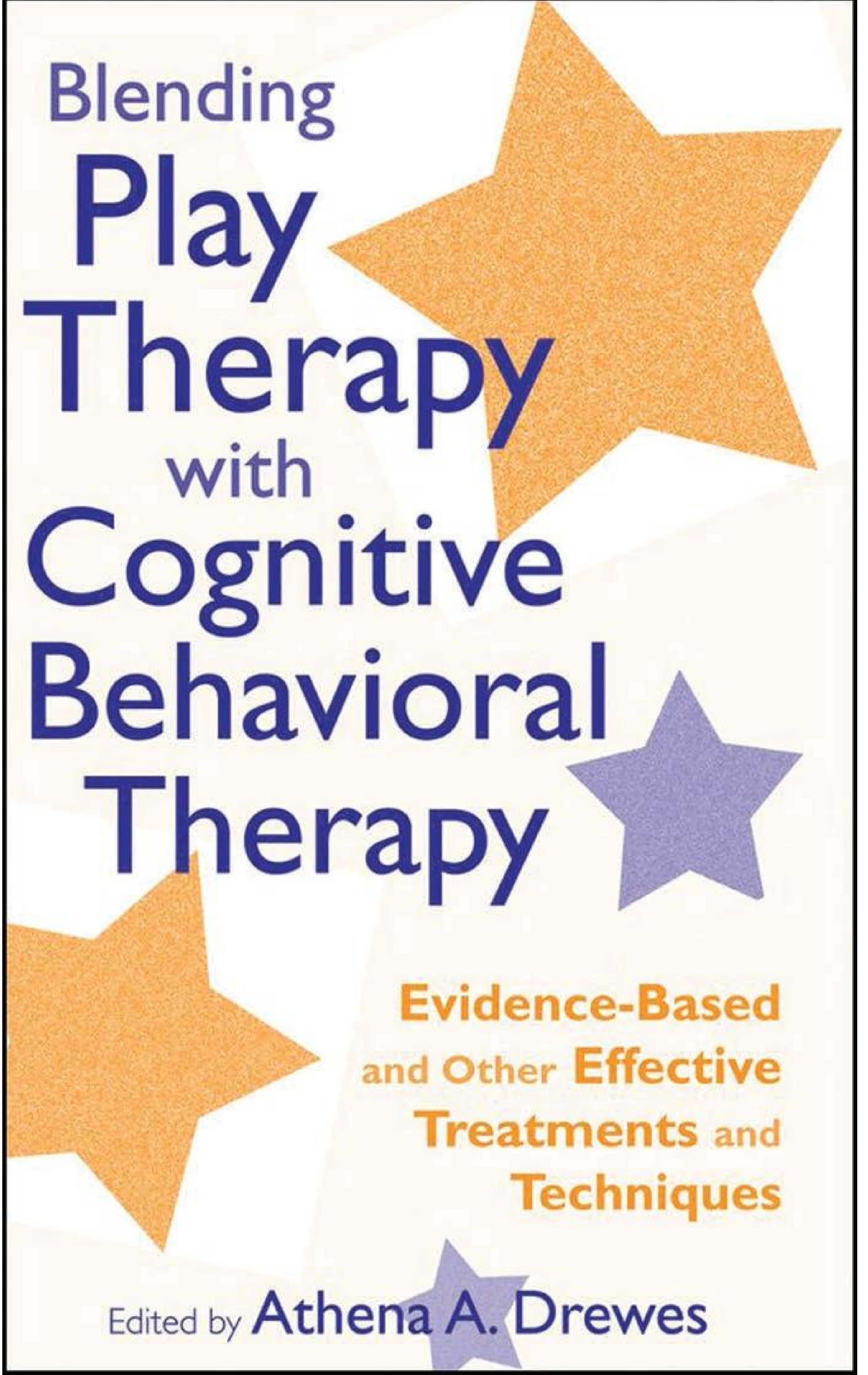

Blending Play Therapy with Cognitive Behavioral Therapy

Evidence-Based and Other Effective Treatments and Techniques

Edited by **Athena A. Drewes**

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Edited by

Athena A. Drewes

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Published by John Wiley & Sons, Inc., Hoboken, New Jersey.
Published simultaneously in Canada.

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Library of Congress Cataloging-in-Publication Data:

Blending play therapy with cognitive behavioral therapy :
evidence-based and other effective treatments and
techniques / edited by Athena A. Drewes.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-470-17640-5 (cloth : alk. paper)
1. Play therapy. 2. Cognitive therapy for children. I. Drewes, Athena A., 1948–
[DNLM: 1. Play Therapy—methods. 2. Adolescent. 3. Child. 4. Cognitive Therapy—methods. 5. Evidence-Based Medicine. WS 350.2 B647 2009]
RJ505.P6B64 2009
618.92'891653—dc22 2008032158

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

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She is also on the Disaster Mental Health Leadership Team of the Red Cross in Greater New York, and a member of the Disaster Response Network of the New York State Psychological Association. She has worked for over 25 year across all settings with children and adolescents, specializing in treatment involving sexual abuse, trauma, attachment disorder, foster care children, supervision, and play therapy in the schools.

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Acknowledgments

WITHOUT THE GUIDANCE and helpful suggestions of Charles Schaefer and Don Meichenbaum, this book could not have evolved as it did. Their wisdom and insight helped me to hone my concept into reality. They were most generous with their time and their opinions. I am honored to count them as friends and colleagues, and doubly proud to have them included in this book. They represent the best of both worlds: play therapy and cognitive behavioral therapy.

This book would not have been possible without the support and encouragement of Isabel Pratt, editor and Lisa Gebo, senior editor at John Wiley & Sons. They have persevered over the past three years tweaking, revising, and pushing for what you will now read. Their faith in this project and in me has been unconditional and greatly appreciated. Isabel Pratt did a masterful job in maneuvering this tome into a polished product that will help leave a lasting contribution to the field of child and adolescent psychology.

Special thanks go to James Richard Bridges, Scott Richard Drewes Bridges, and Seth Andrew Bridges for their always present, unconditional love and support. You are the wind beneath my wings!

Thanks to my family and friends who helped keep me motivated and energized: John C. and Doris Drewes, Nick H. and Rosemarie Drewes, Nick and Laurie Drewes, Nicolette Marie and Natalie Elin Drewes, Eliana Gil, Ana Sutton, Akiko Ohnogi, Debra Sheafe, Twila Smith, Peggie Landrum, Linda Mangelsdorf, Linda Shutts, Janie Keller, Sheila Doherty, Chris Foreacre, and Dave Crenshaw.

Preface

THIS BOOK IS borne out necessity and from over 25 years of professional clinical experience with children and adolescents. My career began after obtaining my master's degree in clinical psychology from New York University. I was employed by the Jewish Board of Family and Children's Services (then known as the Jewish Board of Guardians, Inc.) and worked at the Child Development Center testing and treating latency age children. Eva Landauer was my supervisor and mentor in psychodynamic play therapy. She had been trained by Anna Freud. It was there, at JBG, that my passion for play therapy began and I saw how potent it was to use play *as* therapy, with children using metaphor and play while not saying one word in the session. I was witness to children who made gains, blossomed, and interacted over time through symbolic play.

After five years at JBFCS, I moved to Orange County, New York, with my husband to start a family. My work shifted to being a play therapist at an outpatient clinic, and I worked with a wide variety of ages and problems, but most notably sexually abused children who were living in foster care. The field of sexual abuse was relatively new, and the work often felt like we were improvising and flying by the seat of our pants. We were all struggling for ways to engage the children and find skills that would work with every child in treatment. In time I worked in a special education preschool doing play therapy and parent and teacher consultation, and I also worked a few years in regular education as a school psychologist. As the need for a license loomed by New York State mandates, I returned for a doctorate at Pace University in New York City. Its combined school and child clinical program was the best of both worlds in allowing me to get clinical practicum placements. My clinical internship was at the Astor Home for Children in Rhinebeck, NY, a large, multiservice, nonprofit mental health agency that had an APA-accredited program with a strong play therapy component.

I was fortunate enough to be hired upon completion of the internship and have remained there since, more than 16 years. I worked for 10 years as a clinical coordinator and senior psychologist in the Residential Treatment Center in Rhinebeck seeing children from 5 to 13 years of age whose presenting problems were predominantly the result of sexual abuse and attachment disorder, along with a dysfunctional family.

It was at that point that I saw how traditional child-led therapy was not productive with some of the sexually abused children I worked with. Our work became stagnant. If I did not talk about sexual abuse, they were more than happy to avoid talking about it too. Their play avoided the topic and gave no insights. We were at a stalemate, and I had no tools with which to move the treatment forward. Having discovered the Association for Play Therapy in 1992, I attended a workshop by Beverly James, author of *Treating the Traumatized Child*. She introduced the idea of a developmentally sequenced treatment approach and the need to be directive using play therapy materials and play-based techniques. This was the piece that was missing in my work. Applying her techniques and others learned through attendance at the Association for Play Therapy conferences and workshops with the leading play therapists, an integrated treatment style developed. I realized that in order to work with severely abused and traumatized children, who also had attachment deficits, I needed to become flexible in moving between child-led and directive approaches. I needed to become a prescriptive therapist. I needed to apply the best practices, evidence-informed treatment with this child, at this time, for this symptom.

No longer could it be one size fits all in my treatment of trauma. I needed to use play *in* therapy as well as play *as* therapy. This thinking went against other play therapists who believed, and still believe, that child-led treatment is the only way to work with children. They believed it was the only form of play therapy. I believe you need both: not only child-led, nondirective work with children, but also for some children you need to be directive, and at times you need to do both within the same session. And moreover, I believe you need to bring in cognitive behavioral therapy to help deal with affect regulation, self-esteem issues, problem-solving, and coping and social skills deficits, among other things. Attachment issues often were beneath the severe abuse issues both in the Residential Treatment Center and with the children I see in Astor's Therapeutic Foster Care program.

It was at this point that I realized that the worlds of play therapy and cognitive behavioral therapy can blend together very well. Susan Knell's book *Cognitive Behavioral Play Therapy* confirmed what I had felt intuitively. With the advance of credentialing bodies dictating and mandating the use of evidence-based treatments with the children and adolescents seen at Astor, as an agency, we needed to show that what we did worked. And we needed to learn other evidence-based treatments in our work with children and adolescents, especially those with sexual abuse.

Some professionals and some of the literature continue to question the value of play therapy. In large part this may be because of old views that play therapy is psychodynamic or child-centered and nondirective. Indeed this is a part of play therapy: play *as* therapy. However, the world of play therapy has expanded significantly. It also includes the expressive arts, which allows for sandtray therapy, art therapy, use of narrative storytelling, poetry and creative writing, drama, dance, and music therapy, among many treatment approaches. Parent-child treatment using Filial Therapy, Child-Parent Relationship Therapy, along with Theraplay for attachment disorders are also included under the umbrella of play therapy. More and more over the past several years clinicians working with children and adolescents, be it in a school or clinical setting, are seeking techniques and skills to help them work with this population and the myriad of problems they bring to the clinician. Practical application and an integrated approach in seeing children and adolescents have been developing in the field. Play *in* therapy is becoming more the norm. Clearly one size does not fit all.

Over the past three years I have had three workshop proposals accepted at the American Psychological Association annual conferences, and two at the National Association of School Psychologists conferences. These were skill-based trainings in how to utilize play-based techniques and approaches in working with children and adolescents. The strong attendance at these workshops clearly reflects the changing viewpoint and fading of old biases around play therapy. Clinicians need to embrace treatments that are effective and research evidence that informs their work.

This book grew out of the need to bring an awareness to CBT and mainstream clinicians that play therapy has evolved and is no longer just what was thought of 50 years ago. Play therapy has a lot to offer to the growing use of CBT evidence-based treatments. Play itself has curative factors, and when combined with effective treatment methods it becomes a potential change agent in healing children and adolescents. CBT has a lot to offer to play therapists in creating an integrated treatment approach that allows for generalization of skills. There is a lot that both play therapists and CBT clinicians can learn from and share with one another. There is a need for collaboration not polarization.

The chapters you will read within this book are written by many notable clinicians and researchers, some are play therapists and others are CBT researchers. It has been my privilege to personally know Don

Meichenbaum and Charles Schaefer, both notable pioneers in their respective fields, CBT and play therapy. Readers will be able to read about evidence-based CBT treatments for children and adolescents that utilize play and consider play as an important component in the treatment of childhood disorders. The reader will also learn about how to conduct and critically read research in order to offer the best treatment for their client. CBT clinicians will be able to obtain practical skills and play therapy techniques that they can integrate into their treatment approaches to help engage children and sustain their attention while working on psychoeducational components.

It is my hope that this book will help to dispel biases and misinformation regarding both play therapy and cognitive behavioral therapy by child and adolescent clinicians. All must remain open to the possibility that play can be a useful component and a healing factor in evidence-based practices. Now is the time for the field of child and adolescent psychology to come together and develop a mutual and respectful collaboration, allowing for the best of both worlds.

Athena A. Drewes, PsyD, RPT-S

Foreword

Athena Drewes's edited volume, *Blending Play Therapy with Cognitive Behavioral Therapy*, arrived as I was about to babysit my four grandchildren, ages 8, 6, 4, and 2. My wife and I were in for a fun-filled week of engaging in childhood play behaviors. As my daughter-in-law was leaving, she announced, ''Don't let them take advantage of you!'' For any grandparent, this is a nonsensical request. In fact, I took advantage of them, as I watched, participated, and engaged in various forms of play. In between play activities, when the children napped or were otherwise entertained, I read this engaging and welcomed resource on the functions and the ''healing power of play.''

How do my grandchildren's play behaviors differ developmentally? What are the functions of play in terms of their emotional, cognitive, and social development? These questions were further highlighted when we next all left for Whistler, British Columbia, to attend my youngest son's wedding. While hiking on a trail in Whistler, my four grandchildren and their mother and aunt encountered a sizeable bear no more than three feet away. When they all returned home to tell us of their ''scary'' encounter, they reenacted the entire bear episode using stuffed animal bears, and they used drawings and songs to tell their accounts. We even videotaped their reenactment and watched it together, noting their quick-mindedness, courage, bravery, and family supports.

It is with this background that I now turn my attention to writing this foreword. Since its origin, cognitive behavior therapy (CBT) has incorporated the medium of play to nurture children's affect regulation, teach coping skills, provide psychoeducation, correct misconceptions, help abused children organize fragmented memories, and develop integrative narratives of traumatic events. CBT has also used play as a means of improving parent-child relationships. A number of CBT procedures are described in this volume as applied to socially anxious children (Coping Cat program) and aggressive children (Dino the Dinosaur, Do Turtle, and

Coping Brain Power programs), as are trauma-focused CBT and play-based cognitive restructuring procedures for depressed children and adolescents. These play-oriented psychotherapeutic activities have such titles as ''Beat the Clock,'' ''Hot Seat,'' ''Color My Feelings,'' ''Filling in the Thought Bubbles,'' and ''Role-Playing Spaghetti and Robot.'' A full array of puppet play, sandtray, art expressive techniques, storytelling, and bibliotherapy are described.

The cognitive behavior therapists are indebted to their forerunners who discussed the value of play from psychodynamic and humanist nondirective perspectives and to those who pioneered filial therapy with parents who were taught how to supplement and eventually replace play therapists.

All schools of play therapy are brought together in this volume so the reader can compare and contrast the respective approaches. As Athena Drewes proposes, the goal of this book is to help dispel the biases and misinformation regarding play therapy and CBT and to nurture a collaborative relationship between researchers and clinicians. In large part, the book accomplishes these objectives.

The main reason to nurture such a dialogue is underscored by the findings of a recent meta-analysis of 93 individual play therapy and filial therapy studies conducted between 1953 and 2000 by Bratton, Ray, Rhine, and Jones (2005). These researchers found an Effect Size of $d = .8$, indicating a large treatment effect, relative to control groups. The Effect Size for Filial Therapy by parents was even larger, $d = 1.15$.

Thus, we know that providing distressed children with play therapy has a healing power and contributes to behavioral change. What we do not know is how best to integrate directive and nondirective forms of play therapy; nor what proscriptive algorithms to follow or how best to implement various forms of play therapy; nor what are the active mechanisms in play therapy. How much of the treatment outcomes are a result of the nonspecific relationship with the play therapist, and how much are the result of specific intervention procedures? Is it all DODO bird effects or are there active ingredients that contribute to change? Moreover, why can't troubled children create therapeutic play activities on their own or with peers, without the help of an adult play therapist? The examination of questions such as these will help further blend the science and art of play therapy.

There is one additional nugget in reading this book and that is the final chapter by John Norcross and Athena Drewes on self-care for child therapists. If you can't go home and play with your grandchildren (or children) to recover from a stressful day at the office, be sure to read this chapter.

Play is the way children tell us what is on their minds and what are their concerns and fantasies. If you work with children, this edited volume will help you become a more perceptive listener. Enjoy!

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REFERENCE

Bratton, S., Roy, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of the outcome research. *Professional Psychology: Research, and Practice*, *36*, 376–390.

SECTION I

RATIONALE FOR INTEGRATING PLAY THERAPY AND CBT

SECTION I PROVIDES the reader with three chapters that help to frame the rationale for and benefit of play and play therapy, and why cognitive behavioral evidence-based interventions can become even more effective with a developmental approach that incorporates play and play-based components.

We begin with Chapter 1, Charles Schaefer's and Athena Drewes's overview of how play is universally the child's natural expression and critical to childhood development. Schaefer's 25 therapeutic powers of play, based upon a review of the literature, allows the reader an in-depth view into the change mechanisms within play that can help child and adolescent clients overcome their psychosocial difficulties. Each of the well-known schools of therapy, including cognitive behavioral, emphasizes one or more of the curative powers of play. The authors promote the need for a prescriptive eclectic approach for clinicians whereby child and play therapists become skilled in numerous therapeutic powers and differentially apply them to meet the individual needs of clients. This approach is based on the individualized, differential, and focused matching of curative powers to the specific causative forces underlying the client's problem. The authors conclude with a note that future research is needed to elucidate the specific therapeutic powers of play that are the most effective with specific presenting problems.

This chapter is followed by Janine Shelby and Michele Berk, who address in Chapter 2 the increasing emphasis on and empirical support of evidence-based therapies that are commonly cognitive behavioral in approach. They make the case that while these treatments are effective for adolescents and adults, younger children may not have the skills required to learn CBT techniques that require metacognition. A developmentally sensitive approach is suggested. The authors focus on how CBTs for children and adolescents might be advanced by practices from the education and play therapy literature, which place intense focus on developmentally sensitive methods for interacting with, teaching, and/or delivering therapeutic or academic content. They initially describe two CBT treatments for depression and posttraumatic stress that are commonly used with children and adolescents. They continue with a discussion of findings from the fields of education, child development, and play therapy that can be successfully blended with CBT in order to increase developmental sensitivity, engagement, and experiential utility over verbal methods of instruction. Specific suggestions and examples are given for how the reader can synthesize learning and play therapy methods into CBTs.

This section is rounded out in Chapter 3 with Eliana Gil and Nicole Jalazo offering a unique example of how well science and clinical practice can collaborate in the field of child sexual abuse. They discuss the challenge of therapy with abused children in taking evidence-based approaches and then being able to translate them for use with young, resistant children with limited linguistic and cognitive skills and who may be too anxious to learn cognitive lessons due to chronic and severe trauma. Implementation of evidence-based treatments with children is often hampered by trying to utilize a single approach for all situations. The authors highlight the difficulties clinicians encounter when relying exclusively on techniques or approaches that focus on verbalization and intellectualization. Trauma-focused cognitive behavior therapy (TF-CBT) is highlighted for its empirically researched effectiveness. The authors illustrate how play therapy and play-based interventions, through two case studies, can effectively strengthen the TF-CBT approach, working in tandem. They advocate a Trauma-Focused Cognitive Behavioral Play Therapy approach that is user-friendly and capable of engaging difficult clients, less verbal clients, and most challenging families, as well as facilitates work across cultures.

CHAPTER 1

The Therapeutic Powers of Play and Play Therapy

CHARLES E. SCHAEFER
ATHENA A. DREWES

PLAY IS AS natural to children as breathing. It is a universal expression of children, and it can transcend differences in ethnicity, language, or other aspects of culture (Drewes, 2006). Play has been observed in virtually every culture since the beginning of recorded history. It is inextricably linked to how the culture develops poetry, music, dance, philosophy, social structures—all linked through the society's view of play (Huizinga, 1949). But how play looks and is valued differs across and within cultures (Sutton-Smith, 1974, 1999).

The use of fantasy, symbolic play, and make-believe is a developmentally natural activity in children's play (Russ, 2007). Play is not only central but critical to childhood development (Roopnarine & Johnson, 1994). For a variety of species, including humans, play can be nearly as important as food and sleep. The intense sensory and physical stimulation that comes with playing helps to form the brain's circuits and prevents loss of neurons (Perry, 1997). Play is so critical to a child's development that it is promoted by the United Nations 1989 Convention on the Rights of the Child, Article 31.1, which recognizes "the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts." Play is perhaps the most developmentally appropriate and powerful medium for young children to build adult-child relationships, develop cause-effect thinking critical to impulse control, process stressful experiences, and learn social skills (Chaloner, 2001). Play can provide a child the sense of power and control that comes from solving problems and mastering new experiences, ideas, and concerns. As a result, it can help build feelings of confidence and accomplishment (Drewes, 2005). Through play and play-based interventions children can communicate nonverbally, symbolically, and in an action-oriented manner.

Play is not only essential for promoting normal child development, but it has many therapeutic powers as well. All therapies require, among other factors, the formation of a therapeutic relationship, along with the use of a medium of exchange (Drewes, 2001). The use of play helps establish a working relationship with children, especially those who lack verbal self-expression, and even with older children who show resistance or an inability to articulate their feelings and issues (Haworth, 1964). The presence of toys and play materials in the room sends a message to the child that this space and time is different from all others. It indicates to the child that they are given permission to be children and to feel free to be fully themselves (Landreth, 1983).

Play is used in therapy by play therapists and child clinicians as a means of helping children deal with emotional and behavioral issues. Play therapy and the use of play-based interventions is by no means a new school of thought (Drewes, 2006). The use of play to treat children dates back to the 1930s to Hermione Hug-Hellmuth, Anna Freud, and Melanie Klein. Several adult therapies have since been adapted for use with children, such as child-centered play therapy adapted by Virginia Axline (1947), sandplay therapy evolving out of Jungian theory through Margaret Lowenfeld (1979) and Dora Kalff (1980), and cognitive behavioral play therapy by Susan Knell (1993).

In the safe, emotionally supportive setting of a therapy room, the child can play out concerns and issues, which may be too horrific or anxiety producing to directly confront or talk about in the presence of a therapist who can help them to feel heard and understood. The toys become the child's words and play their language (Landreth, 1991), which the therapist then reflects back to the child to foster greater understanding.

CURATIVE FACTORS OF PLAY

Therapists from differing theoretical orientations have long been interested in the healing or curative factors in psychotherapy. It is only over the past 25 years that child clinicians and researchers have looked more closely at the specific qualities inherent in play behavior that makes it a therapeutic agent for change (Russ, 2004). The goal is to understand what invisible but powerful forces resulting from the therapist-client play interactions are successful in helping the client overcome and heal psychosocial difficulties. A greater understanding of these change mechanisms enables the clinician to apply them more effectively to meet the particular needs of a client (Schaefer, 1999).

Freud wrote of insight, facilitated by the therapist's interpretations and analysis of transference (Schaefer, 1999), as the key component toward curing a client in psychoanalysis.

Yalom (1985) wrote about "therapeutic factors" or change mechanisms that he believed were inherent in group psychotherapy (Schaefer, 1999). They included acceptance, altruism, catharsis, instillation of hope, interpersonal learning, self-disclosure, self-understanding, universality, vicarious learning, and guidance (Schaefer, 1999). Bergin and Strupp (1972) offered critical factors that transcended theoretical schools of thought: counter-conditioning, extinction, cognitive learning, reward and punishment, transfer and generalization, imitation and identification, persuasion, empathy, warmth, and interpretation (Schaefer, 1999).

Schaefer (1999) was the first to describe the therapeutic powers of play. Based upon a review of the literature, he identified 25 therapeutic factors that will be discussed below.

Self-Expression

Developmental limitations in expressive and receptive language skills, limited vocabulary repertoire, and limitations in abstract thinking ability contribute to young children's difficulty in communicating effectively. Perhaps the major therapeutic power of play that has been described in the literature (Schaefer, 1993, 1999) is its communication power. In play, children are able to express their conscious thoughts and feelings better through play activities than by words alone. Children are naturally comfortable with expression through concrete play activities and materials (Landreth, 1993). Use of symbolic representation and expression through dolls and puppets provides emotional distance from emotionally charged experiences, thoughts, and feelings. Through indirect expression in play the child can gain awareness of troublesome affects and memories and begin the process of healing.

Access to the Unconscious

Through the specially chosen toys, games, and materials for their therapeutic and neutral stimulus qualities, the child can reveal unconscious conflicts via the defense mechanisms of projection, displacement, and symbolization (Klein, 1955). With the support of the play therapist in a safe environment, the child can begin to transform and integrate unconscious wishes and impulses into conscious play and actions (Schaefer, 1999).

DIRECT AND INDIRECT TEACHING

Play allows you to overcome knowledge and skills deficits in clients by direct instruction. For example, when you teach social skills to children using dolls, puppets, and role plays, the children are more likely to learn and remember the lessons. The use of fun and games captures children's attention and increases their motivation to learn.

Storytelling and the use of play narratives allow the child to join in interactive fantasy play with the therapist (Schaefer, 1999). This in turn can result in the child learning a lesson or solution to his/her problem (Gardner, 1971). This is a gradually paced, indirect method with room for repetition that allows for less emotional arousal than direct confrontation (Frey, 1993). Play narratives enable clients to organize their fragmented memories and experiences into a cohesive, meaningful story (Pennebaker, 2002).

ABREACTION

Through the use of play, children reenact and relive stressful and traumatic experiences and thus gain a sense of power and control over them (Schaefer, 1999). Through repetitive play reenactments, the child is able to gradually mentally digest and gain mastery over horrific thoughts and feelings (Waelder, 1932). Children show a natural tendency to cope with external events and traumas through play. After the horror of 9/11, many children were observed building towers with blocks and crashing toy airplanes into them. ''Post-traumatic play can be effectively used therapeutically. It is, in fact, the most potent way to effect internal change in young traumatized children'' (Terr, 1990, p. 299).

STRESS INOCULATION

The anticipatory anxiety of upcoming stressful life events, such as a family move, starting school, birth of a sibling, or visit to a doctor or dentist, can be lessened by playing out the event in advance (Wohl & Hightower, 2001). By playing out with miniature toys exactly what to expect and using a doll to model coping skills, the strange can be made familiar and less scary to the child.

Counterconditioning of Negative Affect

Two mutually exclusive internal states are not able to simultaneously coexist, such as anxiety and relaxation or depression and playfulness (Schaefer, 1999). Thus allowing a child to play hide-and-seek in a darkened room can help in conquering fear of the dark. Or dramatic play with hospital-related toys can help to significantly reduce hospital-specific fears. Rea, Worchel, Upchurch, Sanner, and Daniel (1989) found hospitalized children's adjustment was significantly improved (anxiety significantly reduced) for the randomly assigned group that was encouraged to engage in fantasy play with both medical and nonmedical materials.

Fantasy play allows the child to move from a passive to an active role, for example the child can role-play giving an injection to a doll patient. Fantasy play also facilitates the expression of several defense mechanisms such as projection, displacement, repetition, and identification (Schaefer, 1999).

Catharsis

Catharsis allows for the release and completion of previously restrained or interrupted affective release via emotional expression (e.g., crying) or activity (e.g., bursting balloons, pounding clay, or punching an inflated bunching bag) (Schaefer, 1999). Emotional release is a critical element in psychotherapy (Ginsberg, 1993).

Positive Affect

While involved in play, children tend to feel less anxious or depressed. Enjoyable activities contribute to a greater sense of well-being and less distress (Aborn, 1993). In play, both children and adults are likely to elevate their mood and sense of well-being (Schaefer, 1999). Sustained high levels of the stress hormone cortisol can damage the hippocampus, an area of the brain responsible for learning and memory, which results in cognitive deficits that can continue into adulthood (Middlebrooks & Audage, 2008). Laughter and positive affects help to create the opposite effect, releasing mood-boosting hormones or endorphins, lowering serum cortisol levels, and stimulating the immune system (Berk, 1989). Play and playfulness and its potential for mirth and laughter become an antidote to negative affects such as anxiety and depression (Schaefer, 1999).

Sublimation

Sublimation allows the channeling of unacceptable impulses into substitute activities that are socially acceptable (Schaefer, 1999). The child who physically hits another may be redirected, helped to practice and learn through repetition alternative means of expressing negative feelings by using ''war-like'' board games (chess, checkers), card games (war), or competitive sports activities (Fine, 1956; Schaefer, 1999).

Attachment and Relationship Enhancement

Play has been found to facilitate the positive emotional bond between parent and child. Studies of filial therapy (Ray, Bratton, Rhine, & Jones, 2001; VanFleet & Guerney, 2003), Theraplay, and Parent-Child Interaction Therapy (Brinkmeyer & Eyberg, 2003; Hood & Eyberg, 2003) have shown success in promoting parent-child attachment and relationship enhancement (Drewes, 2006). Through step-by-step, live-coached sessions, the parent/caregiver and child create positive affective experiences, such as playing together, which results in a secure, nurturing relationship. Gains are reflected, via research, in improvements in parental empathy, increased perception of positive changes in the family environment, self-esteem, perception of child-adjustment, perception of the child's behavioral problems, along with the child's self-concept, and changes in the child's play behavior (Rennie & Landreth, 2000).

Moral Judgment

Piaget (1932) first asserted that children's spontaneous rule-making and rule-enforcing play in informal and unsupervised play situations was a critical experience for the development of mature moral judgment. Game play experiences help children move beyond the early stage of moral realism, in which rules are seen as external restrictions arbitrarily imposed by adults in authority, to the concept of morality that is based on the principles of cooperation and consent among equals (Schaefer, 1999).

Empathy

Through role-play, children are able to develop their capacity for empathy, the ability to see things from another's perspective. Role-playing different characters in social play has been found to increase altruism (Iannotti, 1978), empathy (Strayer & Roberts, 1989), as well as social competence (Connolly & Doyle, 1984).

Power/Control

Children feel powerful and in control during their play. They can make the play world conform to their wishes and needs (Schaefer, 1999). In marked contrast with the sense of helplessness children experience during a disaster, play affords them a strong sense of power and control. The child towers over the play materials and determines what and how to play during the therapy session. Eventually, this competing response (power) helps overcome the child's feelings of insecurity and vulnerability.

Competence and Self-Control

Play provides children with unlimited opportunities to create, such as through stories, worlds constructed in a sandtray or drawings, whereby they can gain a sense of competence and self-efficacy that boosts their self-esteem (Schaefer, 1999). In addition, by engaging in activities such as game playing or construction play, children can learn self-control through thought and behavior stopping that can help them to stop and think and plan ahead. As a result the child can anticipate the consequences of various potential behaviors and actions. These skills can be mastered through practice opportunities and positive reinforcement and can consequently then generalize into any number of settings (e.g., school, home, social settings).

Sense of Self

Through the play and child therapist's use of a child-led, child-centered approach (Axline, 1947), a child can begin to experience complete acceptance and permission to be himself without the fear of judgment, evaluation, or pressure to change. Through a commentary on the child's play, the therapist provides a mirror, figuratively speaking, by which the child can understand inner thoughts and feelings and develop an inner self-awareness (Schaefer, 1999). Play can also provide the opportunity for the child to realize the power within to be an individual in one's own right, to think for oneself, make one's own decisions, and discover oneself (Winnicott, 1971). Since this is often a unique experience, Meares (1993) noted that the field of play is where, to a large extent, a sense of self is generated. He concluded that play with an attuned adult present is where experiences are generated that become the core of what we mean by personal selves (Schaefer, 1999).

Accelerated Development

Preschool children's levels of development can advance in play beyond the ordinary accomplishments of their age period and function at a level of thinking that will only become characteristic later on (Schaefer, 1999). Vygotsky (1967) observed that children in play are always above their average age and their daily behavior.

Creative Problem Solving

Numerous studies have demonstrated that play and playfulness are associated with increased creativity and divergent thinking in children (Feitelson & Ross, 1973; Schaefer, 1999). Since in play the process is more important than the end product, children can freely, without fear of consequences, come up with novel combinations and discoveries that can aid them in solving their own problems and social problems (Schaefer, 1999; Sawyers & Horn-Wingerd, 1993). Indeed there is ''something about play itself that acts as a vehicle for change'' (Russ, 2007, p. 15). Divergent thinking has been thought to be a mediating link between pretend play and coping strategies (Russ, 2007), whereby children who are good at pretend play (use of affect and fantasy) are better divergent thinkers, have more coping strategies, and could more readily shift from one strategy to another (Christiano & Russ, 1996). Goldstein and Russ (2000–2001) found in a study with first grade children that there was a positive and significant relationship between imagination in play and the frequency of coping responses and variety of strategies used, even when the sample was controlled for IQ. Russ (2007) and Singer (1995) speculate that it is divergent thinking that underlies children's pretend play, a notion that has received empirical support. Being able to think up and find different uses for objects (e.g., clay, blocks), create different endings to stories, or devise scenarios of action can increase divergent thinking (Dansky, 1999).

Fantasy Compensation

In play, children can get immediate substitute gratification of their wishes. A fearful child can be courageous, or a weak child can be strong. Robinson (1970) saw play as essentially a compensatory mechanism operating much like a daydream. Impulses and needs that cannot find expression in real life find an outlet through fantasy.

REALITY TESTING

Play experiences allow children to practice reading cues in social situations and can help differentiate fantasy from reality situations. In social pretend play, children often switch back and forth between the roles they are playing and their real selves (Schaefer, 1999). Frequent engagement in pretend play allows for better discrimination between reality and fantasy (Singer & Singer, 1990).

BEHAVIORAL REHEARSAL

In the safe environment of play, socially acceptable behaviors, such as assertiveness versus aggressiveness, can be rehearsed and practiced. The play and child therapist can model in play new behaviors that are more adaptive for the child through use of puppets and role-play, which the child can then repeatedly practice to ensure skill development and mastery (Schaefer, 1999; Jones, Ollendick, & Shenskl, 1989).

RAPPORT BUILDING

One of the most potent therapeutic powers of play is the relational component of rapport building. This occurs when the client responds positively to the playful and fun-loving therapist. Since most children do not come willingly to therapy, they need to be initially engaged in the process through therapist/child play interactions. Also, since ''play is the language of the child,'' it provides a natural medium for communicating with and establishing a relationship with the child (Landreth, 1983, p. 202).

PRESCRIPTIVE PLAY THERAPY

Each of the well-known schools of play therapy (e.g., client-centered, cognitive behavioral, and psychodynamic) emphasizes one or more of the curative powers of play. The prescriptive eclectic approach (Kaduson, Cangelosi, & Schaefer, 1997) advocates that play therapists become skilled in numerous therapeutic powers and differentially apply them to meet the individual needs of clients. The prescriptive approach is based on the individualized, differential, and focused matching of curative powers to the specific causative forces underlying the problem of a client (Kaduson, Cangelosi, & Schaefer, 1997). When therapists have a greater understanding of these change mechanisms, they can then become more effective in meeting the particular needs of the client.

Norcross (2002) also advocates a prescriptive approach to treatment whereby techniques are modified to match the client's diagnosis or presenting problem. Moreover, therapists should change their interpersonal style of interaction to match the client's style in order to improve treatment outcome.

FUTURE RESEARCH

Although there are numerous outcome studies now attesting to the efficacy of play therapy with children, there are few, if any, process studies of play therapy. Process studies seek to identify the specific mediators, that is, the therapeutic factors that produced the desired change in the clients' behavior. Play therapists also need to look at which change agents in play can be combined to optimize treatment effectiveness. A clearer knowledge of the array of therapeutic factors underlying play therapy will allow child clinicians to borrow flexibly from available theoretical positions to tailor their treatment to a particular child (Kaduson, Cangelosi, & Schaefer, 1997).

CONCLUSION

This chapter has briefly highlighted the various therapeutic change mechanisms within play that can help clients overcome their psychosocial difficulties. The therapeutic factors within play should not be viewed as mysterious but as capable of being understood, altered, and even fully controlled. The use of individualized treatment goals facilitates and guides the therapist in deciding which therapeutic powers to apply. Further research is needed to elucidate the specific therapeutic powers of play that are most effective with specific presenting problems of clients.

This prescriptive matching of change agents with underlying causes will result in the most cost-effective play interventions.

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CHAPTER 2

Play Therapy, Pedagogy, and CBT

An Argument for Interdisciplinary Synthesis

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THE CHILD AND adolescent psychotherapy field has increasingly emphasized the use of evidence-based therapy. One of the most common evidence-based therapies, cognitive behavioral therapy (CBT), focuses on changing maladaptive thoughts and behaviors. Although originally developed for adults, CBT has received empirical support for use with children and adolescents in recent years. However, a number of questions remain about how to best provide CBTs to youngsters. Several authors have discussed developmental considerations that pose challenges to some of the theoretical assumptions of the CBT treatment model (Gravea & Blisset, 2004; McCarty & Weisz, 2007; Ollendick, Grills, & King, 2001; Southam-Gerow & Kendall, 2000; Weisz, Southam-Gerow, & McCarty, 2001). Younger children, in particular, may not have the skills required to learn the cognitively based techniques traditionally used in CBT (e.g., cognitive restructuring, which involves metacognition). Adolescents, who are more cognitively equipped to engage in metacognition and other complex mental tasks, may also experience challenges participating in some aspects of CBTs (e.g., they may not find talk-based therapy engaging; they may be reluctant to participate in the ''homework'' required in CBT; they may have specific learning disorders or cognitive skill sets that make verbal learning or reading difficult; and they may have lowered concentrational and attentional resources, particularly when they attend sessions at the end of a day at school). Adolescents, as well as children, may therefore respond more favorably to the kinds of experiential techniques often used in play therapy and pedagogy versus verbally based techniques. Discussion of youngsters and CBT application has centered on how to best teach children concepts originally designed for adults (Holmbeck, Greenley, & Franks, 2003). There is consensus that CBTs delivered to children and adolescents should be developmentally sensitive (Gravea & Blisset, 2004; Holmbeck et al., 2003; Ollendick & Vasey, 1999; Peterson & Tremblay, 1999; Shirk, 2001), but few specific adaptations and guidelines have been provided (Weisz & Hawley, 2002).

In this chapter, we will describe how CBTs for children and adolescents might be enhanced by practices from the education and play therapy literatures, which have placed intense focus on developmentally sensitive methods for interacting with, teaching, and/or delivering therapeutic or academic content. First, we will describe the two examples of CBTs commonly used with children and adolescents: CBT for depression and CBT for posttraumatic stress. Next, we will discuss findings from the fields of education, child development, and play therapy, which we believe can be blended with CBT in ways that address the potential difficulties described above, such as increasing developmental sensitivity, making treatment more engaging, and utilizing experiential versus verbal methods of instruction. Hence, incorporating techniques from these fields has the potential to make CBTs more effective. We conclude the chapter with specific suggestions and examples of how to synthesize pedagogical and play therapy methods into CBTs.

CBTs FOR THE TREATMENT OF DEPRESSION AND POSTTRAUMATIC STRESS IN CHILDREN AND ADOLESCENTS

Below, we provide a brief review of CBT for child and adolescent depression and posttraumatic stress. A comprehensive discussion of all existing CBT approaches for child and adolescent disorders is beyond the scope of this chapter. We chose to focus on depression and PTSD as exemplars of the CBT approach because they are commonly used, have substantial empirical support, reflect the expertise of the authors, and incorporate standard CBT interventions.

CBT FOR CHILD AND ADOLESCENT DEPRESSION

Cognitive behavioral approaches have shown efficacy in treating children and adolescents with depressive disorders (for a review, see Asarnow, Tompson, & Berk, 2005). Brent and colleagues (1997) found CBT to be more effective than family therapy and supportive therapy in decreasing depressive symptoms in adolescents. Most recently, combination treatment with CBT and antidepressant medication has been shown in two large, multisite Randomized Control Trials (RCTs) to be more beneficial than either treatment alone for adolescents with Major Depressive Disorder (MDD) (TADS, 2007) and superior to medication alone for adolescents with treatment-resistant MDD (Brent et al., 2008).

The CBT treatment approaches used in these studies and in other trials (e.g., Asarnow, Jaycox, Duan, LaBorde, Rea, Murray, et al., 2005) follow a similar core set of interventions. These interventions include self-monitoring of depressive symptoms, pleasant activity scheduling/behavioral activation, cognitive restructuring, and social skills training (see also McCarty and Weisz, 2007). These interventions are comparable to those traditionally used in CBT with depressed adults (e.g., Beck, Rush, Shaw, & Emery, 1979). However, child and adolescent approaches differ from adult approaches, including alterations to the techniques to make them more engaging to the young person and presentation of simplified concepts, as well as the inclusion of family-based modules or interventions. Typical elements used in the CBTs for child/adolescent depression described in this chapter are listed in Table 2.1.

CBT for youth depression typically starts with psychoeducation about the cognitive model of depression. Youth and parents are taught about the connection between feelings, thoughts, and behaviors, how negative thoughts and behaviors lead to negative mood, and how changing thoughts and behaviors can thus lead to positive mood. This sets the stage for the treatment that focuses in detail on activity scheduling and cognitive restructuring.

Behavioral interventions are typically conducted first, with the rationale that behavioral skills may be easier to learn and implement at the beginning of treatment than cognitive skills when the youth is continuing to experience significant depressive symptoms. Deliberate scheduling of positive activities (i.e., ''activity scheduling'') is a key initial intervention because

Table 2.1

Typical CBT Modules for Treating Adolescent MDD

Psychoeducation
Pleasant Activity Scheduling
Cognitive Restructuring
Family-Based Modules
Social Skills Training

depressed youth tend to withdraw from activities that may cause positive mood, thereby creating few opportunities for mood to improve. Youth are asked to complete self-monitoring forms that track their mood and the number of pleasant activities in which they are engaged. From this baseline measure, the therapist works with the youth to increase the amount of positive activities in which the youngster is engaged each week, until he or she reports improved mood ratings. Positive activities can also be conducted with the therapist in the session, such as eating a favorite food together or playing a game.

The next module taught is cognitive restructuring. The youth is taught to notice ''what thoughts are going through your mind right now?'' when he or she is experiencing depressed, sad, or irritable moods. After the youngster becomes skilled at identifying negative thoughts, the therapist teaches the youth to become aware of the impact of his or her thoughts on his or her mood and to change thoughts that negatively impact mood. Standard CBT strategies for restructuring thoughts are used with children and adolescents, as with adults (Beck, 1995), such as identifying cognitive distortions and testing the evidence for the thought. For youth, the cognitive restructuring process is broken down into simple steps to be more developmentally appropriate, and interventions are often made into games in order to be appealing to youth. For example, in a group treatment manual developed by Asarnow and colleagues (1999) for a study of adolescent depression in primary care settings (Asarnow et al., 2005), youth practice cognitive restructuring using the ''hot seat'' game, in which group members call out negative thoughts to the youth on the hot seat, who must immediately answer back with a more positive thought. Another group member serves as a ''coach'' for the youth on the hot seat. In addition, many forms exist for recording and restructuring thoughts that are tailored for younger children, such as faces with cartoon-like ''thought bubbles'' above them where the child can write his or her thought (Friedberg & McClure, 2002). In one study that focused on children (versus adolescents), games and role-plays were included as ways to teach both cognitive and behavioral skills, as well as having the youth create a ''movie'' in which they enacted skills learned in treatment (Asarnow, Scott, & Mintz, 2002). This movie was then shown to parents in a multifamily group, as a means to help parents learn how to help their children use the techniques at home.

Although not the focus of this chapter, family interventions are an important component of CBT for youth depression. It is important for the therapist to review the work done with the youth with the parent, so that he or she may encourage and facilitate these interventions at home. In addition, several interventions can be conducted with the family as needed, with the overall goals of increasing positive affect within the family, decreasing conflict, and providing positive reinforcement for behaviors likely to decrease depression. These interventions include (a) increasing positive affect and support within the family, (b) improving family communication, (c) improving the family's problem-solving ability, (d) contingency management of problematic behaviors, and (e) decreasing parents' high expectations and criticism and increasing positive reinforcement of the teen (Wells & Albano, 2005).

Finally, because social interaction is often difficult for depressed youth, and a lack of social interaction exacerbates and maintains depression, social skills training is a standard part of CBT approaches. Training may include various aspects of social skills enhancement, such as how to initiate conversations, appropriate conversation topics, proper eye contact and facial expressions, and assertiveness (Rohde, Feeny, & Robbins, 2005). Selection and teaching of these skills is done in a way that is intended to be appropriate to the child's age.

Core Components of Posttraumatic Stress Treatments for Children and Adolescents

Several research-based individual and group treatments exist for childhood and adolescent posttraumatic stress and related disorders. In this section, three trauma-based treatments for youth are briefly described. Though not intended as a comprehensive review of either the three selected treatments or of all the research-based treatments for childhood and adolescent posttraumatic stress—some of which are not CBTs—the core components of these three approaches emphasize standard CBT content. Trauma-focused CBT (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Deblinger, 2005) is a widely recognized, efficacious treatment for sexually abused girls. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (Stein, Jaycox, Kataoka, Wong, Tu, Elliott, & Fink, 2003) has research support as an intervention for younger adolescents who have been exposed to violence. The Trauma/Grief Group Psychotherapy for Adolescents (Layne, Salzman, Poppleton, Burlingame, Pasalic, Durakovic, et al., in press; Cox, Davies, Burlingame, Campbell, Layne, & Katzenbach, 2007) has also received empirical support for survivors of war and terrorism. Several other treatments with characteristics similar to those described above have been developed and empirically supported for specific traumatic events (for a review of research supported treatments, see California Evidence-Based Clearinghouse for Child Welfare, 2008; and the National Center for Child Traumatic Stress, 2008).

There is a great deal of shared ground among CBT therapies for childhood and adolescent trauma (see Table 2.2). All of the treatments described above involve the therapist providing psychoeducation regarding common posttraumatic symptoms and the expected course of the trauma-related disorder, symptoms, or issues. There is a focus on clarifying confusion and normalizing posttraumatic reactions. The treatments typically stress the importance of developing or enhancing adaptive coping skills, and include specific interventions to enhance the survivor's use of effective coping strategies. Young survivors are usually encouraged to identify the coping methods that are helpful to them (e.g., by making a list of helpful coping strategies), and asked to employ these strategies when symptoms or reminders of the traumatic event occur. For example, survivors may be encouraged to use positive self-statements, discuss their feelings with a trusted adult, redirect their attention to a more pleasant thought or experience, or distract themselves by engaging in a pleasurable activity. They are generally discouraged from using coping strategies with a high likelihood of negative consequences (e.g., substance-use, repeated and persistent isolation, or negative self-statements involving cognitive distortion). Usually, the coping skills component of the treatment occurs prior to extensive discussion of the traumatic event. This early focus on coping is designed, in part, to prevent or reduce the possibility of an iatrogenic response to exposure-based techniques. Exposure or, more specifically, the construction of a trauma narrative, is a common ingredient among trauma treatments. Although there is variability in the degree to which exposure to the traumatic event is emphasized, the therapies described above involve some degree of exposure (e.g., verbal description, construction of a written account of the traumatic event, or the depiction of parts of the event via drawings). Some treatments emphasize repeated exposure, and other treatments integrate the trauma narrative into the therapy in a more brief and time-limited manner. Cognitive restructuring, particularly regarding misattributions and excessive guilt, is another

Table 2.2
Typical CBT Modules for Treating Children and Adolescents with Trauma-Related Disorders

Psychoeducation
Coping Skills
Exposure to Inappropriately or Excessively Avoided Situations
Cognitive Restructuring
Enhancement of Safety/Caregiver Support

commonality among the treatments. Caregiver involvement in the sessions is encouraged in most of the treatments described above, though the extent of involvement varies considerably across treatments. In most treatments for childhood and adolescent posttraumatic stress, caregivers are provided psychoeducational material to better allow them to place the youngsters' symptoms in the appropriate normative context. Caregivers are encouraged to provide the young survivors with supportive environments, including parental reassurance, nurturance, and the creation of a familial environment in which the child may openly express his or her feeling about the incident, if he or she wishes to do so, to a noncritical caregiver. In TF-CBT, children may engage in a conjoint session in which they describe their traumatic experience to the caregiver, who has been coached prior to the conjoint session to respond appropriately during the child's disclosure. As another common element across treatments, parents, caregivers, or the clients themselves are generally encouraged to take steps to promote safety.

DEVELOPMENTAL ISSUES AND CBT

As described above, many facets of CBT, particularly the cognitive techniques, require metacognition, consequential thinking, and prospective hypothesizing (Holmbeck et al., 2003). These activities involve complex symbolic processes and require a high level of cognitive development, well-developed verbal skills, and the ability to learn via mostly verbal methods of instruction. However, children and adolescents often present to treatment unmotivated (e.g., treatment is often initiated by the parents, not the youth) or with varying levels of cognitive development and capacity (e.g., with learning disorders or lowered verbal intelligence). Given the limited developmental capabilities of younger children, in particular, as well as the myriad of other factors involved with treating adolescents, including the importance of the therapist/young client relationship (see Chu & Kendall, 2004) it is no doubt that the fit between developmental factors and CBT has been questioned.

Several difficulties associated with the application and theoretical underpinnings of CBT—particularly in relation to children younger than 8—have been identified (Gravea & Blisset, 2004; Weisz, Southam-Gerow, & McCarty, 2001). These issues have focused on the following: (a) developmentally related cognitive capacities that pose problems to specific theoretical aspects or underlying assumptions (e.g., mechanisms of change) of CBT; (b) pathognomonic processes (e.g., examination of styles of thinking viewed as pathological in adults and similar styles that are normal for children, such as centristic thinking); (c) cognitive capacities that pose challenges to teaching the content of the model (e.g., abstract concepts or use of hypothetical situations); (d) process-related issues, such as therapeutic alliance; and (e) specific methods of instruction and whether the content or activities are developmentally appropriate and engaging.

With so much research to support the use of CBTs with children and adolescents, how much do these ''discrepancies'' between CBT and child development matter? Existing studies suggest that younger children may not respond as well as older children to CBT treatments. In the Durlak, Fuhrman, and Lampman (1991) meta-analysis, older children (age 11–13) showed nearly twice the effect size of younger children. In another meta-analysis (Weisz, Weiss, Han, Granger, & Morton, 1995), children younger than 12 years of age benefited less from treatment than older children. In Gravea and Blisset's (2004) review, they conclude that mean improvement for youth engaged in CBTs is lower than for adults. Holmbeck et al. (2003) hypothesize that effect sizes in meta-analytic studies on child and adolescent treatments would be larger if treatment was ''tailored to the developmental level of the child'' (p. 22).

A decade ago, Ollendick and Vasey (1999) noted that a widespread developmental-clinical child interface has yet to be realized. In the CBTs described in this chapter as well as among many other CBTs for children and adolescents, efforts have been made to incorporate developmentally simplified language, more adolescent- or child-relevant content, and improved instructional methods. But have CBTs gone far enough in achieving the desired blend between development and CBT practice? Posed from the young person's perspective, are CBTs interesting and fun? The more these treatments are engaging for youth, the more likely it is that they will fully participate in the treatment and homework assignments, which, in turn, increases the likelihood that youth will benefit from treatment.

GUIDING CONCEPTS FROM EDUCATIONAL LITERATURE: WHAT TEACHERS ALREADY KNOW

In the field of education, there has been an intense and long-term focus on integrating factors related to pedagogy, play, and child development. In addition to the vast research literature on this topic, one need only traverse the aisles of a teachers' supply store to find an abundance of instructional handbooks that describe developmentally based play or active learning teaching strategies. A plethora of methods, games, activities, and instructional aids (e.g., posters, stickers, or teaching materials) designed to teach specific concepts are readily available for teachers. The methods and materials are usually stratified by age or grade. The mind-set that children and adolescents benefit from teaching that involves the use of multiple, play-based, experiential activities that vary according to development (i.e., by age or stage of maturation) is fairly standard in the education world.

In order to illustrate this point, consider the following example of two fifth-grade mathematics classrooms focusing on multiplication. In one class, the teacher describes multiplication formulas and demonstrates examples on the chalkboard (i.e., ''If we have two apples and then get twice as many, we have four apples. Two times two equals four.''). The teacher supplements the classroom-based instruction with handouts containing pictures of objects being multiplied by 2 and then by 3. Following the instructional portion of the class, the teacher provides students a chance to demonstrate their skills, including the completion of worksheets with multiplication questions and participation in group repetition drills in which students focus on the memorization of multiplication tables.

In the second classroom, the teacher begins the class by distributing three large T-shirts and two pairs of oversized pants to each of several small groups. Students are asked to identify how many outfit combinations exist. To answer the teacher's question, students may try on the outfits over their school clothes, arrange outfit combinations on the floor, or engage in other experiential methods of their choosing. As the students name the various combination sets, the teacher draws them on the chalkboard. The teacher then asks the students to identify the commonalities across the sets (i.e., there are two types of clothing: pants and shirts) and depicts these in a 2×3 table. Later, when the teacher explains multiplication formulas and multiplication tables, the already learned concept is merely codified. The students learn primarily from their involvement in a teacher-initiated activity, rather than from the teacher's verbal instruction.

Assuming that the students in both classrooms eventually learn to perform multiplication tasks, are the teaching methods equally successful? Or are there qualitative differences in learning between the classes (e.g., student learning preferences, motivational benefits, enhanced levels of interest, concentration, or attention, or benefits to those with lower levels of academic performance or verbal intelligence)? These are among the questions that have been examined in the pedagogy literature. It may be of worth to consider similar questions about CBT with children and adolescents. Several authors have named cognitive skill and motivation as student characteristics that predict the ability to learn (Fraser, Walberg, Welch, & Hattie, 1987; Walberg, 1980). In this chapter, we focus on two additional factors related to pedagogical success: active or experiential learning and teaching methods designed for a range of student learning-style preferences.

The concept of active or experiential learning is frequently referenced in the education literature, and is often described in best practice standards for education (Zemelman, Daniels, & Hyde, 2005), but it has been defined with slight variations across authors. Active or experiential learning generally refers to students engaging in activities that involve *doing* over *listening* (Chickering & Gamson, 1987). Though it sometimes includes verbally based activities with experiential components, the concept of active learning for school-age youngsters more commonly emphasizes participating in hands-on activities, such as science experiments, playing computer-assisted games designed to teach educational content, or play-based activities with specific goals and objectives. Several studies have shown that students either prefer strategies promoting active learning to traditional lectures (see Bonwell & Eisen, 1991) or show cognitive or writing advances that are superior to those shown from lecture-style teaching approaches (Newmann et al., 2001).

The philosophical approach to active learning instructional methods implies more than the mere use of an occasional game or strategy to appease the child so that the youngster can be redirected to a verbal-style instructional method as quickly as possible. In an active learning instructional approach, experiential activities are emphasized as critical to the delivery of content curriculum. In addition to examination of teaching methods (i.e., how teachers teach), research has also focused on learning preferences, abilities, or styles (i.e., how students prefer to learn). Precisely how youngsters learn is a complex question, but one aspect of this issue, learning-style preferences, holds particular relevance to the discussion here. Early learning style research was conducted by Dunn and Dunn (1975) and later by Eiszler (1982), who identified the following 9 learning-style factors from data on adolescent students: (a) reading; (b) manipulative activity; (c) teacher explanation; (d) auditory stimulation; (e) visual stimulation (electronic); (f) visual stimulation (still pictures); (g) games; (h) social interaction; and (i) personal experience. Some authors have found gender-based or academic aptitude-based learning style preference differences. Boys have been found to prefer manipulative activities (Eiszler, 1982; Price, Dunn, & Dunn, 1977) and to have a reduced preference for teaching that focuses on explanation and direction, as well as a decreased preference for learning by reading (Eiszler, 1982). High-achieving students showed greater preferences for learning by reading than moderate- and low-achieving students. Although the Eiszler study advises against developing teaching strategies or materials for individual students based exclusively on a specific learning style, they recommend that teaching materials be expanded to include all preferences/modalities. Other research supports the idea that a significant number of individuals have learning styles best served by pedagogical techniques other than lecturing. For example, college students learned more when instructors reduced the amount of time the instructors spent lecturing and increased the amount of the time the students engaged in paired discussion, mental review of material, and note-taking (Ruhl, Hughes, & Schloss, 1987). All of these findings lend support for the inclusion of active learning methods and instructional strategies that offer students the opportunity to learn in ways that resemble active, hands-on classroom environments over lecture-based or assignment sheet learning.

CAN PLAY BE A ''SERIOUS'' METHOD?

Embraced by teachers, play therapists, and developmental psychologists, and, at times, met with skepticism by some, play has been seen alternately as either a detractor or a supporter of learning (Bergen, 2002). Bodrova and Leong (2003) point out that proponents of play-based programs for young children view play and learning as mutually exclusive, with the idea that serious learning is not playful. Goldhaber (1994) asks in the title of an article ''If we call it science, then can we let the children play?'' This question captures the concerns academic psychology has traditionally had about play therapy. For decades, play therapy has been widely practiced, but the play therapy field has historically emphasized practice over research. Contemporary play therapy, unlike its psychodynamic ancestor, is not a unitary therapy. Rather, play therapy is practiced from many theoretical orientations, including CBT (see Knell, 1993, 1998). Though they may have differing theoretical bases, play therapies share the common belief that play holds inherently helpful, developmentally appropriate qualities that contribute to the effective processes of therapy with youngsters. Recently, empirical support for the use of play therapy has begun to emerge (see the Bratton, Ray, Rhine, & Jones, 2005 meta-analysis), and several small studies supporting the efficacy of various forms of play therapy have appeared in the International Journal of Play Therapy. There are a number of CBT approaches that have emphasized the use of play-based interventions or techniques (e.g., Asarnow, Scott, & Mintz, 2002; Felix, Bond, & Shelby, 2006; Goodyear-Brown, 2005; Knell, 1993; and March & Mulle, 1998), some with empirical support.

Though empirical examination of play therapy approaches may be relatively recent compared to CBTs, play and its relationship to cognition has been examined for several decades (Piaget, 1962; Vygotsky, 1978). Play-based methods have been shown to be effective in teaching children such diverse content as mathematical representations (Sedig, 2008) and dance (Sacha & Russ, 2006). Specific types of play may hold other benefits for young children, including creativity (Russ, 2003), abstract thinking (Russ, 2004), cognitive development (Bodrova & Leong, 2003), children's readiness for school instruction (Blair, 2002; Shonkoff & Phillips, 2000), and competencies such as text comprehension, metalinguistic awareness, and the understanding of the purpose of reading and writing (Roskos & Christie, 2000). In addition to academic correlates, Bodrova and Leong's Tools of the Mind program (1996, 2001) resulted in improved self-regulation modulation and enhanced executive function when children engaged in self-directed dramatic play with predetermined goals (e.g., "to make a meal for my baby doll"). In their review of numerous studies on play, Smilansky and Shefatya (1990) reported support for play as a contributor to the development of and advances in "verbalization, vocabulary, language comprehension, attention span, imagination, concentration, impulse control, curiosity, problem-solving strategies, cooperation, empathy, and group participation."

Though not the focus of this chapter, several researchers have found support for parent-child dyadic treatments that emphasize play, including Parent-Child Interaction Therapy (Herschell, Calzada, Eyberg, & McNeil, 2002; Urquiza & McNeil, 1996), Child-Parent Relationship Therapy (Landreth & Bratton, 2006), Child-Parent Psychotherapy (Lieberman, Van Horn, & Ippen, 2005; Lieberman, Van Horn, & Ippen, 2006), and Filial Therapy (Guerney, 1964; VanFleet, Ryan, & Smith, 2005). Most researchers have not directly examined the role of play as a mechanism of change in these forms of psychotherapy, but the findings nonetheless provide indirect and, at least philosophical, support for the notion that certain types of play or play-based activities may provide benefit to children engaged in psychotherapy treatments.

PLAY-BASED PEDAGOGY AND CBT

Imagine now, two different kinds of psychotherapy sessions that focus on developing adaptive coping skills. In the first therapy condition, the therapist, via verbal instruction, teaches the child to differentiate between adaptive and maladaptive coping strategies. The therapist and child then make a list of potentially helpful coping methods. Next, the youth and therapist discuss future situations in which the coping strategies might be used. In the second therapy condition, the child is shown a set of colorful fish cut from construction paper. On the side the child initially sees (i.e., the side facing up), the cutouts resemble various types of fish. On the side facing downward, there are pictures of children engaged in coping activities with corresponding labels of coping strategies. The pictorial examples are designed so that children understand the essence of the coping strategies without having to read the labels and without therapist explanation, though the therapist provides a brief description of each fish the child selects during the activity. A paperclip attached to the mouth of the fish allows children to use their magnetized fishing poles (e.g., chopstick, pencil, or straw with a magnet attached by a piece of string) to catch the fish. Children are told to go fish for one that might help them feel better and throw back the fish that would probably make them feel worse. After catching a fish, the child examines the picture and the therapist briefly describes the coping strategy depicted on the pretend fish. The child is asked whether the action depicted on the fish is something that would help him or her feel better or worse. The therapist and child briefly discuss the child's rationale, and when the coping method would likely lead to a positive outcome, that fish is retained by the child. When the coping activity would not be helpful, the child throws the fish back, face up (to avoid recatching the same fish). After catching many helpful fish, the child is assisted in creating an individualized coping plan for the child's favorite coping fish (e.g., where the child might use the strategy, when the child might use it, and so forth). The therapist may also practice use of the coping strategy with the child. The helpful fish, along with any additional individualized aspects of the coping plan go home with the child. The therapy homework is to play the fishing game at home, ideally with a caregiver, and use at least two or three helpful fish between sessions.

Both therapy activities are designed to teach children to differentiate between adaptive and maladaptive coping mechanisms and to develop individualized coping plans, but the Coping Fish activity (Shelby, Bond, Hall, & Hsu, 2004) requires little explanation from the therapist, is more likely to be enjoyable for most young children, and requires much less writing and verbal skill than the first, more traditional method. In fact, the child has a solid grasp of the core therapeutic concept *before* the therapist provides verbal instruction or detailed explanation of the concepts. This is not to say that children cannot learn about coping via verbal instruction. To the contrary, research supporting the efficacy of CBT with youth, described earlier in this chapter, suggests that they do. However, we suspect that emphasizing experiential, play-based treatment strategies may contribute to stronger treatment effects, greater motivation to participate in treatment, greater enjoyment in the therapeutic process, and greater benefits to those who have lowered verbal intellectual functioning. Below, we offer specific examples of how to integrate active learning and other experiential techniques into the core components of CBTs. The sample techniques provided below are offered to demonstrate ways in which developmentally sensitive methods might be blended with CBT objectives. The sample strategies provided here are not intended to convey a comprehensive treatment package.

How Select Core Components of CBT Might Be Modified

1. Psychoeducation. In addition to the verbal or reading-based methods typically used in CBT psychoeducation, a variety of developmentally engaging methods can also be used.
   a. Puppet shows may be performed by the therapist to depict informational material with greater comprehension for younger children (Felix, Bond, & Shelby, 2006; Knell, 1993) or children who have low-range verbal intellectual capacity.
   b. Index cards with brief descriptions, labels, and corresponding pictures may be more engaging to some adolescents than reading a brochure or information sheet.
   c. Similarly, index cards with photographs or drawings depicting symptoms may be preferred by less verbal youngsters as a means to identify the symptoms or issues that they are experiencing.
   d. Therapeutic stories that describe posttraumatic symptoms, adjustment, and coping strategies can also be helpful in providing psychoeducational material to young children. March and Mulle's (1998) narrative paradigm in which the child engages in a battle to ''run OCD off my land'' is a creative example of how a therapy protocol can be implemented through a playful conceptualization.
2. Cognitive Restructuring. Play-based methods to demonstrate abstract or complex concepts may assist children in learning. Rather than explaining the relationship between thoughts, feelings, and behaviors, clinicians might engage youngsters in activities involving motoric or kinesthetic games, or the use of manipulative materials or physical activities that are similar to the core CBT concept.
   a. Dominoes placed in a circle (i.e., arranged so that, when triggered, they cause the tumbling of the other dominoes) depict the influence of one action on others. After the child has discovered this relationship via play and manipulative activities, the clinician may then attach three small labels at equidistant thirds of the circle. On each of the three labels (i.e., one word per label), ''thoughts,'' ''feelings,'' and ''behaviors'' are written. The child is, again, invited to push the

triggering domino and to notice the reaction of the other dominos. Next, the child is asked to depict specific thoughts, feelings, and behaviors that apply to his or her problem situation.

b. Three adolescents (or an adolescent and family member(s) or therapist) stand at the pinnacle of each of the three angles in a triangle. Each person holds two pieces of yarn, one in each hand. For each participant, one piece of yarn connects the person to the participant on the right and the other piece is held by the person on the left. One participant states a maladaptive thought and pulls the string to the right, which triggers this person to state a corresponding unpleasant feeling resulting from the thought. After the feeling has been stated, the participant pulls the string to the right, which prompts the third person to name a corresponding maladaptive behavior. The pattern is repeated, as indicated, to demonstrate the spiral of negative thoughts, feelings, and behaviors that can occur with maladaptive thinking processes.

c. A creative technique for cognitive restructuring is Goodyear-Brown's (2005) ''Lose the Bruise'' strategy, in which the youngster is asked to hold both a pretend shield and a plastic sword. After the child names a specific situation and identifies corresponding negative self-talk that interferes with the desired outcome, the therapist states the youth's negative thought while tossing a sponge ball at the youngster. The child or adolescent, who has rehearsed responding to a negative self-statement with a positive self-statement, counters the negative statement spoken by the therapist with an adaptive statement while using either the shield or the sword to defend and protect him- or herself from the negative self-statement.

d. Interactive metaphors or stories can also be used to illustrate adaptive thinking styles. For example, a ''good coach/bad coach'' metaphor has been used in work on both depression (TADS family manual citation) and PTSD (National Center for Child Traumatic Stress, 2004; Shelby et al., 2004). In this technique, youth are asked to name a favorite sports star or athlete. The adolescent is then asked whether the athlete plays a good game, every game. When the adolescent inevitably responds ''No,'' the interventionist can ask the adolescent to either describe or demonstrate (i.e., via play with the therapist) the worst moment of one of the athlete's bad performances. After the adolescent's description or play demonstration, the interventionist asks the client to either role-play or describe what a bad coach says to the player? The adolescent is asked to specifically describe the unhelpful statements that might make the player feel worse. These unhelpful statements (e.g., ''you are a loser,'' ''you never get it right,'' or ''you are a disappointment to the whole team'') are written in the blank cartoon captions on a colorful activity sheet labeled ''What a Bad Coach Says'' (see Figure 2.1). The adolescent is then asked to describe, or demonstrate via play, what a good coach says. Encouraging and helpful statements are then written in the blank cartoon captions (e.g., ''you tried your best,'' ''you'll do better next time,'' or ''just practice until you get the shot down''). After identifying helpful and unhelpful coaching statements, the teen is told, ''You have a coach's voice in your head that talks to you in the same way. What

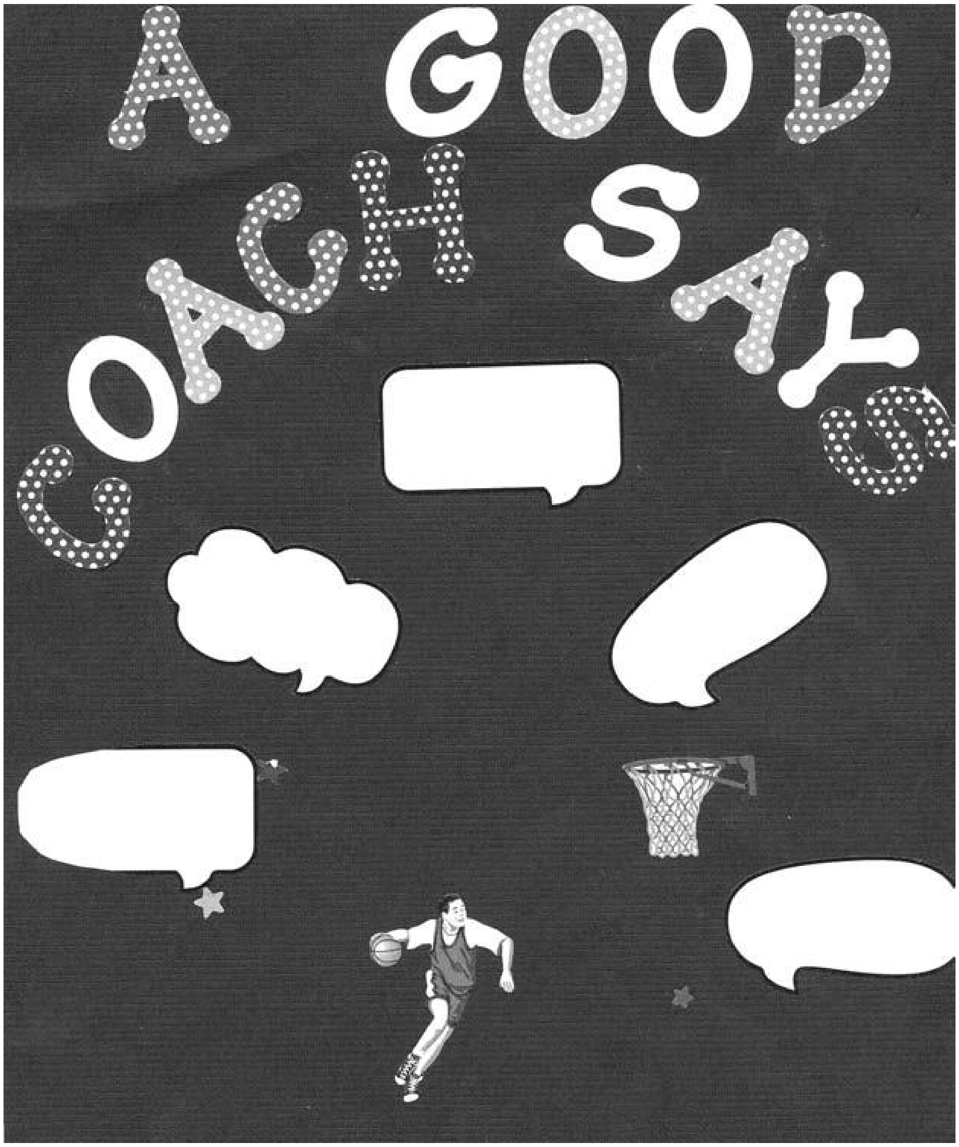

Figure 2.1 What a Good Coach/Bad Coach Says

does your coach say when you make a mistake?'' Then, the therapist and teen discuss the concept of positive versus negative self-statements and agree that the ''Bad Coach'' voice should be fired and replaced by the ''Good Coach'' voice. They might also then discuss and role-play the teen's own use of specific helpful and unhelpful self-statements and practice self-statement substitution.

3. Coping. As just described for cognitive restructuring, coping skills and problem-solving strategies can also be taught via games and manipulative activities. For example, a variation of the Coping Fish game described earlier was developed for use with natural disaster survivors (Shelby et al., 2004) and for the National Center for Traumatic Stress (2004). In the Coping Fish card game, pairs of generally adaptive coping strategies are depicted on playing cards. As in the other Coping Fish activity, each card shows a picture of the coping activity and a label. Generally maladaptive coping strategies are also depicted on other cards, but they do not have a match. Each player is dealt several cards, and asked to try to find pairs that are likely to help children or adolescents feel better. The remaining cards are deposited into the kitty. Players take turns asking other players for matches to their cards. When matches are found, they are placed faceup for all players to see, discussed, and individualized for each player's use. The game ends when players recognize that only maladaptive strategies are left. Children are instructed to play the game at home, with either the cards the therapist provides or with cards they make in session.
4. Therapists may also design a variety of role-play activities that focus on numerous aspects of coping and problem solving. For example, they may be asked to pretend that they are at the mall with only $30 to buy a snack, new clothes for the school year, or both. They are then asked to brainstorm various ways of purchasing clothing or food with only that amount of money. Department store catalogues, clothing advertisements, and fast-food restaurant menus are provided to the youngster to enhance the imaginary shopping experience. The youth is encouraged to discuss the rationale for the shopping choices. After youngsters master basic coping and problem-solving skills, role-plays may be tailored to their particular difficulties, such as role-playing how to solve a conflict with a parent over curfew.

Overarching Recommendations

1. When feasible, CBT therapists should incorporate experiential, play-based strategies for teaching youth standard CBT interventions, such

as psychoeducation, cognitive restructuring, and behavioral coping skills.

2. The experiential, play-based techniques we suggest for CBTs are most likely to be effective when the concept to be taught is an inherent, obvious part of the activity, such that little verbal explanation is required to learn. This allows the youth to first have exposure to the concept, then to figure out the point of the activity through their own experience, and finally, to have the learning solidified by supplemental therapist explanation and discussion.
3. Manual developers should be cognizant that the youngster presenting for treatment in common clinical settings is likely to have verbal intelligence in the average or lower range, may not be motivated to attend treatment (Kazdin & Weisz, 2003), or may have disorder(s) that impinge upon executive functions, attention and concentration, and other cognitive issues. Treatments that are interesting and experiential, with hands-on activities that employ a range of learning styles, have a higher likelihood of generating full engagement.
4. Therapists and treatment developers should consider adapting standards for teaching of specific CBT concepts via developmentally specific techniques that vary by age, grade, level of verbal intelligence, or maturational stage.

CONCLUSION

As Shirk and Karver (2006) point out, ''it is critical to know, first, if the therapy works'' (p.465) before understanding why and how the treatment works. Given the plethora of research supporting the use of CBTs for depression and anxiety among older children and adolescents it is apparent that the therapy works. The interplay between developmental factors and treatment benefit is fertile ground for future questions about how CBTs might work with even greater success (i.e., larger treatment effects, and greater enjoyment among participants). We believe that findings and practices from pedagogy and play therapy, which have emphasized developmentally appropriate techniques, hold value for CBTs as they strive to become optimally developmentally sensitive. We advocate for CBTs with interventions that have been carefully crafted to emphasize, rather than merely include, experiential and play-based learning techniques that cater to youngsters with varied learning-style preferences, varied levels of motivation to participate in treatment, and a range of cognitive abilities. We hope this discussion contributes to the discourse about how to make CBTs more developmentally sensitive and sparks additional discussion and research into the effectiveness of developmentally sound teaching methods, including play-based activities and play therapy, in CBTs.

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CHAPTER 3

An Illustration of Science and Practice

Strengthening the Whole Through Its Parts

ELIANA GIL
NICOLE JALAZO

THIS CHAPTER PRESENTS a unique example of how well science and clinical practice can collaborate in the field of child sexual abuse. Trauma-focused cognitive behavior therapy (TF-CBT) is a wonderful contribution to mental health work with sexually abused children not only because researchers have studied it empirically and shown it to be effective, but also because it captures the basic principles developed over two decades that therapists consider critical in helping abused and traumatized children.

THE MENTAL HEALTH NEEDS OF ABUSED CHILDREN PRIORITIZED

The field of child abuse prevention and treatment formalized itself in the 1960s and 1970s, and by the early 1970s, treatment programs specifically aimed at treating sexually abused children were initiated throughout the country. The earliest efforts concentrated on removing abused children from their homes and placing them in foster care while social workers attempted to provide their parents with parenting education and support.

When social workers attempted to reunite abusive parents with their children, they quickly recognized that removing abused children to foster care and providing their parents with parenting education, treatment, or other court requirements while their children were not in their care was insufficient to prevent the recurrence of abuse. At this point, social workers and other related professionals began to realize that the domino principle on which this approach was based, that is, helping the parents learn new skills that will help the parent-child dyad and the family as a whole, was woefully inadequate, and the concept of providing mental health services to children in tandem with their parents began to develop.

Early thinking about abused children underestimated the children's treatment needs, and Ruth Kempe, Dr. Harold Martin, C. Henry Kempe, and Ray Helfer were probably the first professionals to draw attention to the mental health needs of abused children. In Kempe and Helfer's first edition of their seminal book, *The Battered Child* (1976), they guided readers to deal with children's mental health needs separately from the systemic interventions that provided services for abusive parents and the legal interventions that mandated parents serve jail time, be placed on probation, or be supervised by social services departments. In these early stages of the development of treatment for abused children and their families, the data were insufficient to indicate that abused children who remained untreated could develop the pervasive and long-lasting effects that have been widely documented since (Briere, 1992). Indeed, data continue to emerge targeting symptoms by type of abuse, culminating in the last five or six years in a veritable quilt of expert opinions about the impact of abuse on children's development as well as the specific treatments that can target precise symptoms.

Child sexual abuse has been studied extensively. While the data suggest that symptom lists and profiles may be a helpful context in which to explore the effects of abuse, sexually abused children are clearly unique in how they experience and manage their abuse, and no single profile of abused children is possible (Kendall-Tacket, Williams, & Finkelhor, 1993). Helfer, Kempe, and Krugman (1997) identified the following common difficulties of abused children: a sense of safety, unresolved fears, mistrust, need for nurturing, poor self-esteem, tendency to regress during therapy sessions, poor ability to express emotions both verbally and nonverbally, aggressive behavior, and poor cognitive and problem-solving skills. Thus the earliest advice about abused children emphasized their tendency to exhibit symptoms of post-traumatic stress disorder (fears, mistrust, regression); behavioral and affective dysregulation (poor ability to express emotions, aggressive behavior); problem-solving skills and cognitive processing; and self-reference problems.

Martin (1976) wrote the first treatise devoted to the treatment of abused children, which stimulated a focus on the mental health and developmental needs of such children. Since that time, authors have added hundreds of studies, articles, and books to this lone text. In the late 1970s and early

1980s, several journals specific to child maltreatment debuted and some have become staples of reliable information, for example, the *Journal of Child Abuse and Neglect*, the *Journal of Child Sexual Abuse*, and the *Journal of Child Maltreatment*.

Gil (1991) set forth the premise that the fundamental goals of treatment of abused children are to provide a corrective and reparative experience, and acknowledged that initial treatment efforts need to reduce acute symptomology. She proposed that the necessity to balance the child's need for safety, which is best provided in a nondirective yet structured environment, with the need to provide directive attention to acute symptom relief is challenging but necessary. Gil described the corrective experience as one that provides the child with the experience of safety, trust, and well-being. Furthermore, she noted that the aim of the reparative experience is for the child to process the traumatic event, thereby allowing him or her to consciously understand and tolerate it.

Gil outlined the critical components of a treatment plan for working with abused children as follows: providing the experience of a safe and appropriate interaction with a trusted other; respecting and recognizing the child's individual need for space and structure; providing an ongoing assessment; facilitating exploration, experimentation, and play; promoting self-expression; bridging the unconscious with the conscious for the purpose of processing traumatic experiences; encouraging the relinquishing of secrets and dealing with the fear of keeping secrets; interrupting ''stuck'' posttraumatic play to generate alternatives; treating dissociation; transferring learning from the therapy setting to other settings; and promoting prevention and education.

Gil's more recent book (2006), while still adhering to her basic principles, has incorporated the vast literature and research now available on the treatment of abused children. In particular, she urges consideration of an integrated approach to treatment goals for abused children by developing a therapeutic relationship of mutual trust and respect; helping children to identify their idiosyncratic thoughts, feelings, and behaviors with an emphasis on their phenomenological experiences or attributions; facilitating the expression and externalization of pertinent thoughts and feelings; helping children manage and regulate the expression of affect and behavior; assisting children to understand and broaden their self-definition, self-regard, and confidence; bringing specific trauma memories into conscious awareness (through directive and nondirective approaches); encouraging the integration of memories and the creation of realistic narratives of the trauma (verbal and nonverbal); encouraging and allowing children to release energy and affect through symbolic expression; and processing the experience of trauma within a family context to abandon secrecy and denial and to support strengthening of the family. Gil's vast experience working with abused children has led her to value the integration of expressive therapies with more traditional psychotherapy approaches.

James was another practitioner who began her work at a time when scant empirical data were available to guide her work. While acknowledging some overlap, James (1989) identified four major areas of clinical work with traumatized children: communication, sorting out, education, and perspective (James & Nasjleti, 1983). Communication involves encouraging and facilitating children's expression of their beliefs, emotions, and experiences. Sorting out refers to the process of understanding and validating children's experience of the event and its meaning. Education describes interventions designed to correct misinformation and misconceptions as well as providing children with the tools to manage and control their thoughts, feelings, and behaviors. Perspective refers to children's development of a sense of self beyond the experience of the traumatic event and the understanding that they are not the lone survivors of sexual abuse. James believed that addressing the area of client perspective could help children with the process of accurate integration. Berliner and Elliott (2002) later advanced the area of perspective and labeled it misattributions, referring to the various ways that children can inaccurately blame themselves for the traumatic event, take responsibility for it, develop a sense that they controlled what happened, and the like.

The early practitioners used a practice-based approach that allowed them to use each child's unique experience in treatment as a way to further their understanding of what was useful and necessary for the child to begin to recover from the maltreatment. Even though clinicians did not routinely use psychological instruments to assess young abused children during these early days of treatment and the practice of measuring treatment outcome was in its infancy, practitioners carefully documented their clients' progress, for example, by developing and meeting treatment goals and discussed and shared indicators of progress. Thus many clinicians working with the same population in different settings began to document that children would benefit from breaking their silence, understanding that they were not to blame for the abuse, and being allowed to have and/or express a range of emotions toward their abusers. They also noted that children needed help with affective expression and self-regulation; had to feel supported, especially by their non-offending parents; and had to receive clinical encouragement to process or work through myriad thoughts, feelings, and sensations that had often been frozen at the time when the children were abused and had to employ defensive strategies.

Thus clinicians came to understand that the treatment of abused children and their families had to be abuse focused and that specific interventions had to assist young children to move beyond the sometimes devastating effects of abuse, particularly intrafamilial abuse.

The more information became available from practitioners, researchers, and academics, the more apparent were the patterns in the literature about how to be of help. A review of the historical development of mental health services specific to abused children reveals a clear persistence in identifying what specific approaches and formats would constitute effective assistance to families in need. Those involved appeared to agree that the domains of cognition, emotion, and behavior required rigorous attention and would obviously need to be approached differently depending on the child's gender and developmental age and stage. Friedrich (1995) provided one of the most useful comprehensive conceptual frameworks by advocating concurrent attention to ego development, dysregulation, and attachment within individual, group, and family therapy contexts.

A task force of the National Child Traumatic Stress Network focused on the issue of complex trauma (long-term trauma usually experienced in the family and community) and identified a consensus of impairment areas to be addressed by clinicians. These areas include problem areas in attachment, biology, affect regulation, behavioral control, cognition, and self-concept (Cook, Blaustein, Spinazzola, & van der Kolk, 2003), yet again advancing the notion that most experts agree on the core components of trauma treatment (Berliner, 2005).

PRACTICE AND EMPIRICAL STUDY

It seems that the best methodology for continuing to improve, refine, reevaluate, and expand treatment practices seems to occur in the natural collaboration between practice and science. In this interactive and respectful exchange, an ongoing feedback loop provides more specific refinement of ideas, particularly when professionals who may or may not have an investment in a specific approach and who may have differing levels of expertise with the target population implement approaches identified under clinical trial conditions in a variety of settings. The many clinical experiences that clinicians, program directors, and researchers documented or shared through case illustrations helped to identify and prioritize the topics or goals to be included in a structured therapy approach.

Thus when TF-CBT was developed and articulated primarily by Deblinger and Heflin (1996) and Cohen, Mannarino, and Deblinger (2006) in response to a void in empirically-based treatment practices, the approach reflected a specific focus. This emphasis was on child and family psychoeducation, on misattributions and cognitive thinking errors, on expressing emotions in healthy ways, on the need for controlled and gradual exposure to the traumatic event so that children could gain a sense of mastery and restored control, and on assisting children to create a cohesive narrative that would further discourage the use of such defensive mechanisms as denial and dissociation. More specifically, those professionals working on general trauma issues turned their attention to what became known as complex trauma and contributed a great deal of knowledge about trauma, about its links with dissociation and dissociative disorders (including dissociative identity disorder), and about the need to maintain a focus on the impact of trauma on the many dimensions of each person (physical, cognitive, emotional, spiritual factors).

In the early 1970s, Gil remembers being influenced by Bennett Braun, Frank Putnam, and Bessel van der Kolk, who were discussing the issue of trauma, and yet a splintered field initially maintained different fields of study: one for trauma and one for child abuse and neglect. Few people in the field of child abuse prevention and treatment were aware of the work of those studying trauma and vice versa. Currently, however, the two fields function interactively, and researchers in both are aware of each other's contributions and undertake joint studies. The field of trauma studies has by definition maintained a broader scope and looks at global traumas, such as the effects of terrorism, war, natural disasters, and school shootings (as opposed to the interpersonal trauma of childhood abuse and neglect). A recent book by Perry and Szalavitz (2006) chronicles some extreme types of severe abuse and neglect, details its effects on children's development (particularly development of the brain), and provides yet another layer of data that contributes to the work of Siegel (1999), who has elicited renewed excitement in understanding the brain, how interpersonal abuse impacts the development of the brain, and how brain changes occur as a result of chronic stressors during development. Perry and Szalavitz (2006) and Stien and Kendall (2004) have proposed neurologically based interventions, offering yet additional examples of science impacting clinical practice. Perry and Szalavitz promote one of the expressive therapies, music therapy, as an important aspect of their neurosequential model.

THE TF-CBT: A MANUALIZED, EVIDENCE-BASED APPROACH

Likely one of the most well-marketed therapy manuals, Cohen et al. (2006) is the definitive book that lays out the specific components of TF-CBT. These components have been tested in research conducted primarily by three groups of authors (Cohen & Mannarino, 1993, 1996, 1997, 1998; Cohen, Mannarino, Berliner, & Deblinger, 2000; Deblinger, Stauffer, & Steer, 2001). In addition, the National Child Traumatic Stress Network (NCTSN), a prominent organization in the field of child sexual abuse treatment, emphasizes the need to utilize evidence-based treatments and documents those therapies that have been tested and proven effective with abused children and their families. In addition, the NCTSN has rated a number of treatment approaches as ''promising'' (and one of those approaches is Trauma-Focused Play Therapy discussed later in this chapter). NCTSN provides information and a tutorial program (http://www.nctsnet.org and/or www.musc.edu/tfcbt) on the TF-CBT treatment. NCTSN asserts that TF-CBT is currently held to be the treatment of choice for sexually abused children and their families and notes that it is one of the few evidence-based practices in the field. Specifically, the goals of TF-CBT include psychoeducation, environmental safety, stress inoculation training, and skill building in relation to coping strategies, gradual exposure, affective and cognitive processing, safety and prevention skills, parental involvement, behavior management skills training for parents, and family therapy sessions.

At the same time, Saunders et al. (2003) note the evolving nature of our current database. In fact, new compelling treatment models continue to emerge that merit serious consideration (see, for example, Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP), developed by the Chadwick Center for Children and Families (Taylor, Gothard, & Igelman, 2004)). Discussion continues on how best to address trauma in young children, integrating evidence-based practices, specifically when working with complex trauma (Shelby & Felix, 2005).

ADAPTATION OF TF-CBT

In recognition that one approach may not work for all children, those who distribute the TF-CBT manuals and those who are funding federal treatment programs suggest that the manualized approach be seen as flexible rather than rigid and call for clinical creativity to implement the goals of TF-CBT. Specifically, many of the federal grants awarded in the last few years have funded adaptation programs of TF-CBT. Based on our experience traveling across the country providing training on working with abused children (Gil) and direct experience with applying TF-CBT approaches with children and their families (Jalazo & Gil), we have first-hand knowledge of the challenges involved in engaging all children in the

TF-CBT tasks (even when using puppets, art, and other traditional play therapy techniques). These difficulties are related to the young ages of some children, the children's perception that we are asking them to do something akin to homework, the degree of emotional upset and need to avoid direct work on the abuse, and the reality that many children may be unable or unwilling to do cognitive work early on because they are anxious, fearful, or avoidant early on in treatment.

As mentioned earlier, building a therapy relationship has long been valued as relevant to working with abused children given their level of distrust, fear, and worry and because how abused children have experienced abuse is unique to individual children. Therapists therefore need to discover how to build a relationship of safety and trust with each child while concurrently understanding how the brain works in relation to storing traumatic events and remaining mindful that children's expression of traumatic events is multidimensional. The challenge of therapy with abused children is to take evidence-based approaches and translate them for use with a broader population that includes young, resistant children; children with limited linguistic and cognitive skills; children who are too anxious to learn cognitive lessons; children who are chronically and severely traumatized; and children who simply cannot pay attention or participate because of dissociative responses triggered in the context of interpersonal relationships in which they are the focus of attention. Clinicians will need to build a repertoire of options when they encounter the limitations inherent in any single approach.

Those clinicians with expertise in working with abused children would like nothing better than to be aware of one set of practice skills that would work with every child in their practice. However, without exception, therapists talk about the difficulties of relying exclusively on techniques that focus on verbalization and intellectualization. For a multitude of reasons, both biological and emotional, some children are unable to respond to or engage with words in a meaningful therapeutic way. Van der Kolk et al. (2007, p. 282) describes traumatic memories as ''qualitatively different from memories of ordinary events.'' His research has shown that during exposure to reminders of traumatic events, the Broca's area of the brain, the area responsible for translating human experience into language, does not function at its full capacity, suggesting that such memories are inaccessible through means that rely on verbal expression.

In fact, Perry (2006) has recently pleaded that clinicians be retrospective when choosing how to help children heal from their traumas. Perry takes his cue from traditional healing practices across cultures and finds some core elements that might serve us currently. ''These core elements include an overarching belief system—a rationale, a belief, a reason for the pain, injury, loss; a retelling or reenactment of the trauma in words, dance, or song; a set of somatosensory experiences—touch, the patterned repetitive movements of dance, and song—all provided in an intensely relational experience with family and clan participating in the ritual'' (p. x). Perry then masterfully asserts that these practices are critical in that they provide a healing response that targets the neurobiological experience of trauma. His work seems to embrace an integration of approaches from the expressive therapies as well as the evidence-based approaches (e.g., eye movement desensitization and reprocessing).

Many therapists use the TF-CBT as a baseline, contextual framework that charts a specific course and then define alternative treatment options that also emphasize controlled re-exposure or help their clients construct a narrative via directive, yet not necessarily verbal, communication. In this context, note that children may achieve controlled re-exposure in different ways than adults. Specifically, children seem to find physically reconstructive tasks afforded to them through play to be useful. The concept of posttraumatic play, that is, a literal reconstruction of traumatic events, appears to be the child's natural gradual exposure. As originally documented by Terr (1990), children who seek out literal toys to play out the trauma are attempting to expose themselves to the difficult aspects of trauma, create a sequence of behaviors that begins a narration of what has occurred, accomplish controlled recall, and likely begin to tolerate overwhelming emotions by recreating the trauma at a safe distance. Because play therapists are working with children who can so effectively cope with stressors in novel ways, maintaining receptivity to how they might play out the trauma is critical. The DSM-IV-TR used this receptivity when expanding the definition of posttraumatic stress disorder to include child-specific behaviors. Specifically, when discussing ''specific culture and age features'' in the diagnostic features section, the following statement was included: ''Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars) (DSM-IV-TR, 2000, p. 466).

Play therapists are usually open to narration in many forms and recognize that children retell their experiences through stories they tell, poems they write, songs they sing, sequences in which they play, and art they create as well as their behavior. Indeed, play and other therapists alike regularly select and use toys, games, and art activities because they recognize their potential value. Schaefer (1983) identified play therapy, whether used casually to break the ice or to welcome children into therapy, as having many curative properties, including having positive effects on communication, problem solving, and developmental growth. Schaefer also identified play therapy as useful for children who have experienced psychological trauma. Even though empirical data (regarding play therapy) are scarce, more recent efforts in the play therapy field are beginning to yield data to support its use (Ray, 2006; Ray, Bratton, Rhine, & Jones, 2001). Shelby and Felix (2005) discuss the relative merits of directive and nondirective therapy approaches, including play therapy, and promote the use of good assessment to identify symptoms that therapists then target for interventions.

Some of the professional literature continues to question the value of play therapy partly because it remains misunderstood: many professionals who have not received training in play therapy find its use whimsical or prone to the use of clinical overinterpretation, thus making it seem very subjective. Indeed, when the TF-CBT model has been compared to other play therapy models, psychodynamic, nondirective play therapy was selected by researchers, which by definition is probably not sufficiently abuse focused to be the play therapy treatment of choice for abused children.

ABUSE-FOCUSED PLAY THERAPY

Gil (2006) posited that when play therapy was utilized in the treatment of abused children, it has to be abuse focused. This means that clinicians need to identify, respond to, and advance posttraumatic play in abused children since it actually meets the same goal as that proposed by the CBT concept of gradual exposure. Trauma-Focused Play Therapy therefore acknowledges the value of one of the key components of TF-CBT, gradual exposure, as a factor that can promote mastery and control in abused children. Children who engage in posttraumatic play create play sequences that precisely reproduce their traumatic experiences. Creating opportunities for and receptivity to posttraumatic play not only elicits this retelling, but as therapists witness this play reenactment, they can offer a behavioral description of the play that will allow children to begin to form a realistic narrative of what occurred.

TRAUMA-FOCUSED PLAY THERAPY

Trauma-focused play therapy thus allows for and/or encourages children's use of posttraumatic play. Gil (2006) outlines the following steps for trauma-focused play therapy:

Select toys purposefully to represent trauma aspects and allow children to use them as literal symbols of the trauma, making them visible in a prominent location in the room.

1. Allow children to approach and engage with selected toys naturally.
2. Direct children's attention to the toys and encourage them to play with the toys if they avoid them in subsequent sessions.
3. Observe and document thematic material with special attention to the sequence and outcome of play.
4. Observe and document the repetition of play.
5. Provide a verbal narrative during the play, providing behavioral descriptions but not interpretations or suggestions.
6. Encourage children to expand on the information by asking open-ended questions if they are already providing a narrative.
7. Inquire into the play and invite some verbal communication of thoughts, emotions, and behaviors in the play, for example, ''How does the bear feel when his mom leaves him alone?'' as opposed to ''Why does the bear feel sad?''
8. Observe the evolution in play outcomes. If children introduce healthy, adaptive elements, note those. If they get stuck in repetitive play with no change in outcome, introduce the concept of options by stating, for example, ''I wonder what the bear wishes might happen now.''
9. Do not state solutions for children. Allow them to arrive at those solutions on their own. You can provide two or three possibilities but no specific option.
10. Encourage dynamic movement of some type, either by encouraging movement of toys, giving voices to toys, or asking children to move about the room.
11. Articulate or listen to narratives of children's play when they engage in repetitive play.
12. Note when they discharge affect, change the sequence of play to include more adaptive outcomes, and experience a sense of mastery.

As a result of children utilizing posttraumatic play in this fashion, they can begin to develop feelings of well-being and restoration of power. As this occurs, their symptomatology can also decrease. Once children have processed their trauma using play therapy, they may be more receptive to psychoeducational information, including group therapy.

The Use of Expressive Therapies

There is abundant evidence that the creative arts have long been considered beneficial to the mental health and health care fields. Indeed, the benefits of expressive arts have been discovered in many settings by a variety of helping professionals, and its use has been documented in schools, hospices, churches, prisons, pediatric and geriatric units, and so on, and they have an increasingly recognized role in mental health, rehabilitation, and medicine (McNiff, 1992). Malchiodi (2005) defines expressive therapies as ''the use of art, music, dance/movement, drama, poetry/creative writing, play, and sand tray within the concept of psychotherapy, counseling, rehabilitation or health care'' (p. 2) and further defines them as ''verbal and nonverbal because verbal communication of thoughts and feelings is a central part of therapy in most situations'' (p. 4). Most expressive therapy techniques are considered action oriented, participatory, and to require clients to invest their energies in their therapeutic process (Weiner, 1999). In doing so, clients often gain insight into their thoughts and emotions and find new ways of communication. A growing number of journal articles, unpublished and published dissertations, and books encourage the use of the expressive therapies to advance therapy goals with a range of target populations (Malchiodi, 2008). In addition, Crenshaw (2006), using the term ''evocative strategies,'' has encouraged the use of stories, drawings, storytelling, imagery, fantasy techniques, role-playing, symbolic play, drama, rituals, and dreams to engage children who are traumatized and to advance their healing.

The TF-CBT model advocates for affective expression and modulation, and we firmly believe that expressive therapies can address the affective constriction or hesitancy characteristic of traumatized children. The more familiar clinicians become with expressive therapies (both theory and technique) the more they will be able to optimize their chances of engaging children and encouraging their full utilization of the mental health services that they offer.

PSYCHOEDUCATION IN TRAUMA WORK

In addition to being a significant aspect of any trauma-focused treatment approach, psychoeducation is interwoven into the entire TF-CBT model. Cohen et al. (2006, p. 59) describe the goals of psychoeducation as normalizing ''both the child's and parent's response to the traumatic events and to reinforce accurate cognitions about what occurred.'' Some children need a safe distance from the material that clinicians need them to understand and learn. This safe distance allows them to engage with, process, and incorporate new information into their belief system and understanding of trauma and their own experience. Psychoeducation can be provided in myriad ways that are engaging and maintain children's attention, maximizing their learning of important concepts.

VIDEOTHERAPY AND BIBLIOTHERAPY

Videotherapy and bibliotherapy (Malchiodi & Ginns-Gruenberg, 2008) allow children to process important, trauma-focused aspects of treatment within a safe distance by discussing book characters or watching other children's stories. The film *Breaking the Silence*, for example, portrays the experience of four children who have been abused. These four children share their stories of abuse and describe their physical, cognitive, and emotional responses to the abuse. The underlying message of the video is that adults should listen to children and children should tell if they are being hurt. Each of the children's stories ends happily, with the children receiving the help and the support they need to live happy and fulfilling lives.

PREVENTION PROGRAMS REGARDING TOUCHING

Childhelp (Scottsdale, AZ) has a good touch/bad touch prevention program that includes a series of poster cards colorfully depicting different kinds of touches, including loving touch, fun touch, bullying touch, and sexual abuse. These poster cards offer children the opportunity to discern what distinguishes different kinds of touches while also exploring the feelings, thoughts, and responses of the children illustrated. The cards can generate questions about what the child in the picture might be thinking or feeling as well as what the child might do to get help.

The child's book *Amazing You: Getting Smart About Your Private Parts* (Saltz, 2005) is another example of a storybook that teaches children about their bodies and the private parts of their bodies in a way that is not overwhelming or threatening. Children read about other children describing how bodies are different, how exploring their bodies is natural, and how certain parts of their bodies are so special that they need to keep them private.

A wealth of material is available to clinicians who wish to use books, videos, songs, pictures, and so on to bring to life the education of children with regards to their experiences of trauma. The multitude and variety of material available allows clinicians to be creative in finding what meets the unique needs of the particular children they are working with.

Clinical Case Example One

Andrew is a six-year-old European American child who was referred to treatment following a disclosure by his older sister that the family's babysitter had been touching her. In subsequent interviews with Child Protective Services, Andrew reported that the babysitter, Raymond,

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had also touched his private parts in the context of a game. Andrew was highly anxious and guarded during these interviews and was not able to share any particulars of the abuse. Conversely, his older sister had been definitive that she had told the babysitter to stop, that she had told him what he was doing was inappropriate, and that she had told him if he tried to touch her again she would tell her parents.

Andrew's parents expressed fears about how the abuse would affect Andrew and his sibling and expressed shock and anger that someone they had trusted to take care of their children had hurt them instead. When Andrew's mother participated in an intake interview, she stated that she wanted him to come to treatment so that Andrew could ''get everything out'' about what had happened to him. During the intake session the mother was coached to talk with Andrew about coming to therapy.

At Andrew's first session, he separated easily from his mother and walked with me back to my office (Jalazo). He was pleasant and engaging as well as quiet and curious. As Andrew checked out my office, I shared with him that this was a place where kids came when someone had touched their private parts. I told him that kids have different kinds of thoughts and feelings when someone touches their private parts and that this was a place he could talk, play, or draw about those feelings.

The sandtray immediately caught Andrew's attention, and he spent little time exploring the rest of the room once he saw it. I explained to Andrew that he could build a scenario in the sand using as few or as many miniatures as he wanted (and which were displayed on shelves in the room). Andrew eagerly scanned the shelves to carefully select the characters and objects that would make up his sand scenario.

Andrew began by placing large and characteristically dangerous animals in his world. He then added several alien characters and shared that the ''bad animals'' and aliens had ''destroyed the world.'' In this world the large, dangerous animals and aliens ran rampant. Andrew shared with me that some of the good guys were trying to round up and capture the bad animals to put them in a zoo. Andrew added a car running recklessly over a bridge and shared with me that the car might crash into the fences and let out all the bad animals that had already been captured.

I noticed that Andrew had added a king figure to his world that seemed to be observing the fighting and chaos among the animals and aliens. I asked Andrew what the king thought about what was happening around him. Andrew shared with me that the king was ''thinking it is pretty dangerous'' and also shared that even as the good guys were trying to fight the dangerous animals and aliens, the good animals (elephants) were not convinced that the good guys were not trying to capture them as well. Andrew shared that the good animals were scared and that they thought the good guys were going to lose this battle. During this first sand scenario Andrew externalized some of his concerns, namely, the possibility and danger of destruction, the presence of threatening and powerful ''bad'' forces, the presence of ''good'' forces that remained doubtful and pessimistic, a moving vehicle that could veer out of control and cause more danger, and the presence of an authority figure who observed the chaos and noted that things seemed dangerous.

During Andrew's second session, he headed back to the sandtray and began to pick many of the same miniatures to add to his world. Andrew shared that in this world there was a good dinosaur (Brontosaurus) fighting against a bad dinosaur (T-Rex), thereby making the conflict between good and bad a central focus. I asked Andrew what the two dinosaurs were fighting about, and he responded that they were fighting to determine whether the world was going to be safe or evil. Andrew added a much larger team of ''good guys'' to help the good dinosaur. Andrew also added some new characters whose sole purpose was to try to stop the fighting all together. Andrew added a miniature memorial to the world and explained that this memorial listed the names of people who the bad dinosaur had killed. The king returned to his point of observation, and I asked Andrew what the king was thinking about this time. Andrew shared with me that the king felt that the good guys had plans for how to win, but that they did not realize yet that these plans would work and that they could win. Andrew also shared that even though there were three good dinosaurs, the bad dinosaur would eventually win because he was still stronger. Interestingly, this second scenario suggested that Andrew was interested in the conflict between good and evil, had reinforced or buffered the good forces, had interjected possible rescuers, and had memorialized the death or loss of specific (good) people killed by evil. In addition, the authority figure was able to emphasize that the good forces had a plan of response, yet continued to feel distrust in their ability to succeed, especially as the bad forces seemed to be extremely powerful.

During Andrew's third session, he returned to the sandtray to further expand on the sand scenarios, or narrative stories, that he had

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created previously. He added a graveyard to the center of his sandtray world. Andrew shared that the graveyard was for those who had died in the previous attacks by the bad dinosaur. He also added the bad dinosaur, but this time contained him by fencing him and his alien counterparts within a firm wall. Andrew placed a shark in front of the wall and shared that the bad guys were staying behind the wall because they were afraid of this shark. Andrew shared that the good guys wanted to win this war for gold. He then stated that they also wanted ''evil to be gone.'' Andrew added more and more protective characters and elements in the sand scenario, including dogs to sniff out bombs that the bad dinosaur may have hidden. Andrew also shared that the larger good animals protected the child animals by keeping them hidden behind them. I asked Andrew how the small child dinosaurs felt, and he shared that they felt very scared. Once the king was placed back in his place of observation, I asked what the king was thinking this time. Andrew shared that the king knew the good guys were going to win this time. In making this sand scenario, Andrew made another graveyard to memorialize those killed in battle, contained the evil force behind a firm wall, added a protective animal who apparently frightened others, organized the good forces and motivated them with a reward, placed objects that could detect dangers not readily seen, and had his authority figure proclaim that success was attainable.

In just three sessions Andrew had been able to externalize his experience of the trauma. Although less able to talk about his feelings because he is a six-year-old boy who did not know that the touching was wrong, but who also felt embarrassed and somewhat afraid, Andrew chose to talk about it by playing out scenarios that denoted the conflict between good and evil, vulnerability and danger, backup resources, decreased fear and anxiety, and the reconstituting of safety. In his play he was able to show what was on his mind, work out what would happen, and give himself an experience of mastery in which the ending of his stories provided a sense of renewed safety. Andrew did not appear to have been highly traumatized by the babysitter's inappropriate advances, probably because the abuse was not chronic, his parents believed the children and did not fault them, and he had received protective action quickly. However, it is clear that Andrew was quite stressed out by this experience and that it had elicited in him the reality of good and evil forces in the world, how some experiences can feel dangerous and overwhelming, how he was able to access his internal and external resources to once again feel secure and stable, and how he was taking cues from his parents that things would be all right in the future. It was also interesting to see Andrew use memorials to commemorate those killed by evil. My guess is that he may have been burying a sense of innocence as he and his family faced the reality that sometimes trusted others can become dangerous and behave in hurtful ways. Another possibility is that Andrew was indicating his sense of loss in relation to his contact with the babysitter.

Without having to detail the specifics of the sexual abuse by his babysitter, which was uncomfortable for this young child, Andrew was able to bring the important issues of safety, trust, and loss into the session and process these events in a way that made sense to him and that was comfortable and did not elicit a need to resist or protect. Once Andrew was able to process this event in the metaphor, the actual experience no longer had the power it once did, and Andrew spoke more openly and freely about the specifics of the sexual abuse. By playing it out, Andrew was able to tolerate his feelings, have the experience of physical mastery, and make sense of his experience. Verbalizing his thoughts and feelings at his own pace reinforced his feeling of restored personal control.

Andrew shared with me that he had not realized that Raymond touching him had been wrong, but that he had felt a little weird, embarrassed, and scared when he was being touched. He also knew that his sisters were angry with Raymond for touching them and making them feel uncomfortable. Andrew shared that his sister told their parents about the touching and that was how it had been found out. Andrew shared that his parents were extremely angry and fired Raymond and that he did not see him again. He also mentioned that Raymond was his only boy babysitter and that sometimes he missed him. I used the Color Your Feelings techniques and some directive art therapy tasks to encourage Andrew to identify the feelings he had about the sexual abuse and about his relationship with Raymond. Once Andrew had concluded his posttraumatic play in the sandtray—the three sand scenarios—he was more verbally interactive and responsive, seeming almost relieved. At this juncture I invited him to participate in an art-based activity, and he cooperated easily.

I chose to use a technique adapted by Gil (2006) from Drewes, (2001) titled Color Your Feelings (Hopkins, Huici, & Bermudez, 2005). This technique is designed to assess children's ability to identify emotional

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states and the intensity of emotional states. The clinician asks the child to identify the feelings that he or she has *most of the time* and lists these feelings on one side of the paper. For children who have difficulty identifying the names of feelings, the clinician may use emotion posters or feeling cards to allow them to pick from a range of captured expressions of feelings. This would also be an opportunity to give names to their feelings. Once a child has identified his or her feelings, the clinician directs him or her to choose a color that best shows each feeling and create a color code that matches a feeling to a specified color (Gil, 2006, pp. 88–89). The clinician then draws a gingerbread figure and asks the child to use the colors to show the feelings the child has, how big or little they are, and where in the body he or she feels them. With this intervention children are not only learning to identify their feeling states, but also are beginning to identify the connection between their experiences, feelings, and physiological responses.

Using the Color Your Feelings technique, Andrew identified feeling mad, bored, scared, sad, angry, and happy most often in his body. Andrew designated each feeling with a color and then began to fill in the gingerbread figure I had drawn onto his piece of paper with the different colors according to how much and where he felt these feelings in his body. Andrew colored the top part of his head red to show that he felt ''mad in his head.'' Andrew then colored a small green section in the middle of the head to show that sometimes he felt a little bored in his head. In the bottom half of his face and head Andrew colored a light blue that he had designated as sad and right below sad he filled the neck with a grey for angry. The entire rest of the body with the exception of his stomach was colored a light blue (similar to the color of sad), which he designated as happy. In his stomach Andrew colored black to show that he felt scared in his stomach.

Rather than continuing with the Color Your Feelings exercise to further determine and identify his feelings during specific times when the abuse was occurring, Andrew offered to draw four different pictures of himself. The first picture Andrew drew was how he felt when Raymond was his babysitter: a simple picture of himself smiling. Next Andrew drew a picture of himself after Raymond was gone in which he is frowning. The next picture Andrew drew was how he felt when Raymond was tickling him, and he drew a smile with a circle around it on the face. I asked Andrew to tell me about that face for clarification, and Andrew shared he was smiling and laughing because tickling made him laugh. The final picture Andrew drew was to depict how he felt when he found out that Raymond was not supposed to touch his private parts. Andrew drew the same figure as the third time, but without a bottom half or legs. The face on the figure was a straight face without a smile.

Thus far in my work with Andrew I had used two key components of TF-CBT: the creation of a narrative and feelings identification. The order of the treatment and the manner in which these goals were achieved also make the case for adaptation. Andrew's sandtrays and drawings helped me to identify further goals of treatment, which included another critical component of TF-CBT, psychoeducation around the body and healthy boundaries.

I introduced Andrew to the good touch/bad touch series of poster cards to further our discussion of appropriate boundaries and touches. I began by sharing the cards depicting appropriate touch with Andrew. These cards showed children giving hugs, tickling, riding down slides together, and kissing among other appropriate touches. I asked Andrew to help me figure out how we could tell what kinds of touches they were. Andrew shared that you could determine how the people were feeling about the touches based on their facial expressions. As we went on with the cards, Andrew was able to identify that in some of the illustrated examples one person seemed to like the touch while the other person did not. Andrew and I spoke about what it was like for the person who did not like the touch, and then talked about what that person could do. Andrew shared that the child who did not like the touch should tell someone. I pointed out to Andrew that in one of the pictures the adult seemed to be telling the child to ''shh.'' I asked Andrew what he thought was happening, and he shared with me that the adult was probably telling the child not to tell. I asked Andrew how that child might feel, and Andrew shared that the child might not want to get the adult in trouble. Andrew and I were able to use the illustrated examples in the good touch/bad touch series to identify what makes a touch appropriate or inappropriate. We were also able to explore what kinds of feelings children might have if they are being touched and what might keep them from telling or push them to tell. At the end of this session Andrew created his own illustrated drawings, one in which a boy was touching another boy's penis and the other of two children giving each other high fives. Andrew shared that he enjoyed high fives, but that it was not okay for boys to touch other boys' penises.

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Andrew could be described as a typically shy child, who after several interview attempts by Child Protective Services was described as guarded and shut down. By allowing Andrew to choose a variety of activities, including play, art, and storytelling, Andrew felt free to show what issues had been elicited as a result of being molested by a babysitter. Andrew was engaged and open, partly because he was given some control. Just as he had withdrawn in the context of direct questions, he was able to come forward when given a freer clinical experience. Andrew did not avoid the topic, but instead raised many salient issues that troubled him and needed to be addressed. In later sessions Andrew was more receptive to verbal interactions and became receptive to additional interventions.

Clinical Case Example Two

Tabatha is a four-year-old African American child who was referred due to severe neglect and sexual abuse by her mother. There was scant referral information except for the fact that this child had two mentally ill parents with concurrent drug addiction. The family had moved from state to state, experienced homelessness, and Tabatha had recently been placed in her third foster home. Unfortunately, the child had been removed from the first foster home as a result of taking a knife to the family dog and was removed from the second foster home due to being sexually abused by a teenager who also was being fostered in the home. A medical exam showed conclusive physical findings for sexual abuse, and Tabatha's behavior provided a picture of hyperarousal and dysregulation. Specifically, Tabatha masturbated in public, grabbed the genitals of adult strangers, both male and female, had difficulty sleeping without night terrors, exhibited indiscriminate behavior, and seemed to have anxious attachment to her caregivers. It was virtually impossible to maintain Tabatha in childcare because her aggression and sexual acting-out were so pronounced.

Tabatha's first through third visits were completely chaotic. I (EG) met with her in a midsize play therapy room stocked with a dollhouse, puppets, stove, sandtray and miniatures, and easel and pens. She was unable to regulate herself in order to focus, and her behavior seemed frenetic. In the second session she took off her underwear on the floor and spread her legs so that I could see her vagina. I picked up her underwear, handed it to her, and said, ''This is a place where you could keep your underwear on and I keep my underwear on. Please put your underwear back on.'' She ignored me at first and then picked up her underwear and put it back on. During the first session she came over to me and hugged me numerous times, almost clenching me around the neck in despair. My impression was that she was trying to anchor herself and decrease her anxiety. I handed her a big rabbit so that she could hug. She was able to hug the rabbit frequently and carried it around by the arm, later flinging it around the room and knocking things down. I maintained a very calm and accepting approach to Tabatha, using primarily a nondirective approach while providing limit-setting as needed.

In our fourth and fifth sessions, Tabatha still exhibited hyperarousal in the room with me. She would run to me, hug me, lead me by my hand to play with her, kick me, and ask to go to the bathroom. I would later break her of this habit of visiting the bathroom repeatedly by asking her foster mother to take her to the bathroom before we went into the therapy office. When I did take her to the bathroom, I used this as an opportunity to talk to her about privacy. She wanted me to come in and help her take her pants down or put her pants up, and I reiterated that she knew how to pull her pants up and down, that the bathroom was a private place, and that I would wait for her outside. During these early sessions, Tabatha seemed to be testing the boundaries of our relationship: Repeatedly she would walk over to where I sat, rub her vagina on my knee, and look to see what I would do. Each time I told her in a tempered voice, ''It's not okay with me that you rub your private parts on my knee. Let's do something else.''

By the sixth session, Tabatha was walking, not running, to the office and began to calm down a little. She developed an interest in the dollhouse and had begun piling furniture and people into one room. She placed multiple male figures in a bed, threw wine and beer bottles all over the floor, took some of the very small pots and pans in the toy kitchen and threw them in the room, and began to talk about ''mommy needs to wake up and find me.'' I repeated, ''mommy needs to wake up and find you.'' Sometimes Tabatha would ask, ''Where is mommy?'' ''You're not sure where mommy is,'' I repeated and then added, ''I'm not sure where your mommy is either'' (a true statement since mother was missing).

(Continued)

Tabatha began to use repetitive play, which I surmised was posttraumatic play. She constructed many scenarios in one room of the dollhouse. She also identified an African American girl who she seemed to use to represent herself. Of the many scenarios in the room, the most distressing one to her (she seemed to hyperventilate and usually ended the play with aggressive activity) was an interaction between the mother and child doll. She would first clear out all the people in the room and bring wine bottles and put them around the mother doll. She began to make moaning noises and then took the clothes off the mother doll. She then put the little girl doll so that the face was between the mother's legs. ''Don't push me, mommy.'' She would take deep breaths, and then she would begin to use the little doll to hit the mother, hit the people in the other room, and hit everything around the house, including the walls. After these sessions, the foster mother reported increased masturbatory behavior in Tabatha and nightmares that would awaken her.

I decided to begin to make some interventions with her posttraumatic play. In particular, I thought it was important to advance the creation of a cohesive narrative and begin to assess this child's ability to introduce some healthy variables to the play. My first approach was to narrate what I saw the child do in behavioral terms. For example, I would say, ''the little girl is with the mother, and the mother is drinking wine.'' I would proceed, ''the little girl's face is touching the mother's private parts . . .'' ''She's licking,'' she corrected me. ''The little girl's face is licking the mother's private parts.'' ''She doesn't like it,'' she added. ''The little girl doesn't like licking the mother's private parts,'' I repeated. In this fashion, over time, she and I reviewed the posttraumatic play. We spent four sessions going over the same sequence of play, adding information as I could. For example, when we asserted that ''the little girl doesn't like licking the mother's private parts,'' I wondered out loud, ''I wonder what the little girl is thinking just then.'' Tabatha added, ''She doesn't like it.'' I would then repeat the sentence and add the new information. We added thoughts (or words she heard in her head) as well as feelings in her heart, feelings in her body, what she heard, and what she smelled. Tabatha took my lead and began adding more and more information. At one point Tabatha looked at me and said, ''How come my mommy likes this?'' I responded, ''I don't know Tabatha. I know that it's not okay for mommies to make their little girls lick their private parts. She made a mistake when she did this. It's just not okay.'' Tabatha asked, ''Your mommy doesn't do this?'' ''No,'' I said, ''most mommies don't do this.'' She then said in a loud voice, ''Mommy Mrs. Gloria doesn't lick my privates . . . I don't lick hers too!'' Tabatha was beginning to understand that the licking of private parts was not a common experience. As Tabatha went from one important play processing opportunity to another, I continued to present a narrative or expanded Tabatha's narratives so that cognitions, affect, and sensory information were included. As we talked about thoughts and feelings, I encouraged Tabatha to either give a voice to the doll she had chosen to represent herself and others in her play, or I would ask what she thought or felt about specific situations herself. Over time, Tabatha developed a repertoire to express her emotions, reach out for help, and identify exactly what she was feeling. In addition, she and I used some feeling faces to identify the intensity of the feeling she reported. ''How big is that feeling?'' I would ask, and Tabatha would point to a small, medium, or large circle with a face representing the emotion. Tabatha transferred the work in the therapy session to her interactions with her preadoptive family and often reported things she was learning about emotions from her family. One day she came in and announced, ''Mrs. Gloria used to spank her other children, but she doesn't spank me!'' When I asked Tabatha how she felt about not being spanked, she said, ''Are you kidding? I'm very happy happy!''

As I worked with Tabatha, I asked Mrs. Gloria to come into our session at the end of treatment. At this point, Tabatha got into the habit of telling Mrs. Gloria what she and I had played with in the therapy hour. Tabatha originally wanted to include Mrs. Gloria, and I followed her lead. I felt it was useful to have Mrs. Gloria see what was going on in treatment so that she could set limits, use empathic listening, and respond to Tabatha's behavior in the same way as I demonstrated. During the course of our first three months of treatment, it had become clear that the Department of Family Services was going to request termination of parental rights (TPR), and Mrs. Gloria had been identified as a prospective adoptive parent for Tabatha. In fact, Mrs. Gloria and Tabatha established a healthy attachment fairly quickly, especially once it was clear to Mrs. Gloria that Tabatha was reacting in expectable ways to her early traumas and would likely be able to make considerable progress should her environment become stable.

After working on the specifics of the sexual abuse as well as the context of parental neglect and mother's incapacitation due to

(Continued)

substance abuse, Tabatha moved to the sandtray creating a series of scenarios in which she externalized some of her worries and seemed to achieve closure and mastery. Initially, she picked a mother kangaroo and her joey. She took the mother and buried her under the sand. She put the joey on top of the mound of sand where her mother was buried and then began to say ''Mommy isn't home, mommy isn't home.'' She then had a series of ''visitors'' who would bring her gifts and some of the gifts were scary while some were food and milk. Each time, she would thank the visitors for the milk and/or food and set up a little dining room area to feed the joey. During these times, Tabatha would often go to the little oven, make food with clay and/or sand, pretend to cook, and then portion out the food for me and Joey. It was very important that Joey ''take his time eating'' and that he ''eat up all his good food.''

Another primary scenario that Tabatha developed was one in which visitors asked to use the bathroom and the bathtub. ''No,'' she would say, ''these are private places and I can't share them with you!'' Eventually, she sent these visitors away and told them to ''find your own bathroom.''

Tabatha also spent some time undressing, bathing, and drying a babydoll. This was an elaborate play that took up the whole 50 minutes. Tabatha and I would prepare a bathtub with warm water (apparently Tabatha had been given cold-water baths and was initially terrified to take baths). Tabatha was very interested to find the perfect combination of hot and cold water so that the water was ''just right'' for the baby's bath. We used actual baby shampoo since Tabatha wanted to make sure the baby's eyes would not sting. When she undressed the baby, she asked me to turn around ''so you can't see her privates'' and when the baby was done with her bath, Tabatha quickly wrapped her in a towel and handed her to me for drying. Tabatha had laid out the baby doll's clean clothes and after drying and powdering the doll, would dress her with great care. ''Now you look like a nice and pretty baby,'' she would say to the doll.

After about five months, Tabatha had done some remarkable work and she had stabilized a great deal. Everyone who came into contact with this child marveled at her resiliency. I shared that perception, but I also marveled at Mrs. Gloria's ability to be patient, reassuring, calm, and incredibly loving to Tabatha. Mrs. Gloria believed from the very beginning that Tabatha would respond to a loving, safe, and consistent environment. She had remained positive even when Tabatha grabbed her genitals, asked her husband to lick her privates, tried to stick a pencil in her cat's rectum, and was rejected by other parents in the neighborhood. She persevered, and slowly but surely Tabatha's behaviors began to become calm, loving, and appropriate.

Mrs. Gloria and I discussed the need to do some formal psychoeducation, and we spent about three sessions reviewing some prevention education materials. I coached Mrs. Gloria to provide this information to Tabatha in a way that was consistent with her other parent education. Tabatha listened and learned, and we both felt confident that we could begin a termination process.

Tabatha was a very severely abused youngster who had awesome resiliency. She had reacted most appropriately to her early childhood maltreatment and developed ways of alerting the world that she was in severe distress. Surely her symptoms of aggression, sexual acting-out, dysregulation, and indiscriminate attachment could be understood in the context of what she had experienced. I have always believed that children attempt to make sense of their experiences and/or ask for help by crafting behavior that can speak for them what they cannot put into words.

Tabatha was able to create posttraumatic play by which she externalized her perceptions, concerns, fears, or wishes. By creating more detailed narrations that reflected her posttrauma play, Tabatha was allowed to assimilate the various traumatic memories she had experienced. Because these were in the context of primary relationships, Tabatha also had to reconcile her unmet needs and shift her loyalty to a new parent figure. By re-creating play scenarios in which she could take active control, Tabatha gave herself mastery opportunities. By engaging in this trauma-focused play therapy, this child processed her traumas in ways only she could design.

SUMMARY

We have chosen the treatment of child sexual abuse as a way to illustrate the point that science and practice work in tandem and are strengthened by each other. Recent tendencies to diminish one particular practice to promote another or to pit one good practice or approach against another are counterproductive. The reality is that when a good practice is supported by research, and when research is guided by good clinical work, this is something to be celebrated and shared. Just because one practice is evidence based does not in and of itself decrease the merits of another. In other words, the validation of TF-CBT does not invalidate other treatment approaches with abused children and their families, particularly those approaches that share identical goals. Many traditional practices are also based on good theory and are implemented with great care. Those of us working with abused and traumatized children need to develop a mutually respectful relationship, functioning in a less polarized way, and as collaborators, not as competitors.

Finally, we need to remain open to the possibility that evidence-based practices can always be improved. If the clinical community that is implementing what is currently considered to be the treatment of choice (based on underlying research) repeatedly cites implementation problems, we need to ensure that we continue to study how to make our practices more user friendly and capable of engaging the most difficult clients, the less verbal clients, and the most challenging families and to work across cultures. The bottom line is that science and practice strengthen each other and that the clinical community can learn a great deal from observing the collaboration that now informs the treatment of child sexual abuse.

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SECTION II

HISTORICAL CONTEXTUAL FOUNDATION

CHILD AND PLAY therapists often are not well versed in understanding statistics, critically evaluating research, and understanding the differences between evidence-based and empirically based treatment and evidence-based practice. These issues are often not presented at play therapy conferences or in the literature resulting in no one single place where a child clinician can get a coherent overview so that they can make informed choices about which treatments they should utilize. This section offers three chapters that address research. The section is started with a chapter by Suzanne Button and Lauren Hallion, which allows the reader a quick tutorial on how to understand, use, and conduct psychotherapy outcomes studies. It is followed by a chapter written by Jennifer Baggerly, who offers a criteria-based overview of the play therapy research and its empirical support. This section then closes with Susan Knell reviewing cognitive behavioral play therapy through theory and application.

Chapter 4 begins with Suzanne Button and Lauren Hallion addressing the key skill set of being able to critically evaluate and systematically apply treatment strategies identified as ''evidence-based.'' The authors assist the reader in clarifying the variations in definitions of what constitutes an evidence-based practice, how the quality of evidence behind any given treatment should be judged, and what real-world criteria must be met in order for a treatment to be deemed effective with a given client population. Throughout the chapter they outline the basic skills and knowledge needed to understand concepts and evaluate outcomes research. It is this editor's hope, as well as that of the chapter authors, that play therapists, in particular, will gain a better understanding of how to read and evaluate research, and thereby eventually feel emboldened to do their best to apply quality treatment research to work with clients, and aspire to conduct and contribute their own research to the growing knowledge base about effective practice.

Critics have stated that play therapy has limited empirical support. Yet, there is a rich history of studies that demonstrate the effectiveness of play therapy. In Chapter 5 Jennifer Baggerly discusses the philosophical and historical foundation for play therapy research, identifies the breadth of play therapy research, illuminates meta-analysis findings, describes recent play therapy and filial therapy studies, and makes suggestions for the direction of future research. This chapter reviews current standards espoused by the American Psychological Association for evidence-based practice. The chapter concludes with future research directions, with consideration suggested in examining single-case design experiments. Further it is suggested that the integration of play therapy into cognitive behavioral therapy with research comparisons of Trauma-Focused CBT with Trauma-Focused Cognitive Behavioral Play Therapy be considered by child and play therapists.

Susan Knell concludes this section with her presentation of cognitive behavioral play therapy (CBPT), which is a developmentally appropriate treatment, designed specifically for children 3 to 8 years of age. It is an offspring of cognitive therapy as conceptualized by Aaron Beck and integrates play therapy and play-based interventions that are developmentally appropriate and engaging for younger populations. Cognitive therapy with its emphasis on verbal interventions and play therapy with its focus on play seemed initially to be incompatible. However, over the past 10 years adapting cognitive therapy for preschoolers has received increasing attention. The author proceeds to show how CBPT is based on the cognitive theory of emotional disorders and cognitive principles of therapy, but adapts these in a developmentally appropriate way sensitive to the developmental issues of children and emphasizes the empirical validation of effectiveness of interventions. The reader is able to understand the phases of treatment, methods, and interventions that are utilized, similarities and differences between CBPT and traditional play therapies, as well as how cognitive therapy is translated for use with young children.

CHAPTER 4

Data Are Not Mysterious

Understanding, Applying, and Conducting Psychotherapy Outcomes Studies

SUZANNE BUTTON
LAUREN S. HALLION

> Not everything that counts can be counted, and not everything that can be counted counts.
>
> —Albert Einstein

As is illustrated in previous chapters, the integration of empirically supported treatment strategies with strategies traditionally used and trusted by expert clinicians is a complex endeavor and involves diverse levels of knowledge and skill. In this chapter, we address a key skill set needed in the endeavor: the ability to critically evaluate and systematically apply treatment strategies identified as ''evidence based.''

There currently is enormous variation in definitions of (a) what constitutes an evidence-based practice; (b) how the quality of evidence behind any given treatment should be judged; and (c) what real-world criteria must be met for a treatment to be deemed effective with a given client population (O'Donohue & Fisher, 2006; Norcross, Beutler, & Levant, 2006).

In the face of such variation, what is the busy clinician to do? In order to refocus the evidence-based practice debate on the effective integration of science and practice, clinicians must learn to apply available research to improve the quality and cost-effectiveness of care. However, this application must be conducted with appropriate respect for the complexity inherent in the measurement of human behavior, human relationships, and behavioral change, and without devaluing the importance and impact of reasoned clinical judgment (Bergner, 2005; Chorpita et al., 2002; Goodheart, Kazdin, & Sternberg, 2006).

It is clear that today's practicing clinician must be capable of critically examining available treatments for clients. The ability to read and evaluate the scientific literature in behavioral health is an essential skill for practicing clinicians. However, scientific literature is not the only source for identifying best practices. Data on treatments that work are available through clinician observation of client response and from clients' collaborative input about treatment effectiveness (Goodheart et al., 2006; Wampold, 2001; Norcross et al., 2006). Practitioners must focus on ''using all sources of information to give the best possible odds of a successful outcome'' and evaluate how evidence-based practices stand to benefit their clients and how they may fail to meet all of their clients' needs (March et al., 2005, p. 275; Weisz, 2004).

This chapter will outline the basic skills and knowledge needed to begin this examination. Concepts needed to understand and evaluate outcomes research will be reviewed. Additionally, the chapter will present a basic approach to identifying core practice components that are evidence-based, systematically applying those components to a given problem in assessment, treatment planning, and intervention, and monitoring patient outcomes (Burns, 2003; Chorpita et al., 2002). Finally, the chapter will outline some key strategies to approaching the conduct of outcomes research.

It is important to acknowledge, however, that true mastery of these skills is beyond the page limits of this chapter. When clinicians have mastered this chapter, they will be able to understand the treatment studies they read, evaluate them critically at a basic level, and apply evidence-based treatment components to their work. They also may be able to approach the idea of conducting clinical research. Readers are encouraged, however, to use the list of readily accessible and easy-to-use resources (see References section and Appendix 3 at the end of this chapter) to deepen their understanding of the concepts introduced here and to maintain current knowledge of the ever-expanding list of evidence-based treatments.

By knowing how to read and evaluate research, doing their best to apply quality treatment research to work with clients, and aspiring to contribute to the growing knowledge base about effective practice, clinicians can provide the best possible care at the individual practice level while improving behavioral health care as a field.

UNDERSTANDING PSYCHOTHERAPY OUTCOMES STUDIES

Treatment outcomes research attempts to establish whether a treatment is likely to be effective (Task Force, 1995). Published outcomes articles use a wide array of research designs and statistical techniques to determine whether clients who receive a certain treatment improve as a result of that treatment. When evaluating a treatment, researchers look for *statistically significant* improvements, improvements that can be demonstrated mathematically. Recently, research also has considered whether improvements are *clinically significant* (i.e., whether the treatment actually has made a noticeable difference in the client's overall well-being or functioning). Not all of this research is of equivalent scientific merit, however. How, then, does one recognize a good outcomes study?

First, issues related to *bias* (a person or group's tendency to lean toward a certain belief, regardless of evidence to the contrary) must be considered. Bias is an important concept in research, and quality studies must take certain steps to reduce bias wherever possible so that results are not misleading.

Good outcomes research uses careful techniques when selecting participants for a study (*sampling*) in order to reduce bias. Imagine, for example, that a study of adult women's dessert preferences is conducted. The researcher might stand in front of an ice cream shop and ask every woman who enters the ice cream shop what type of dessert she likes best. Upon data analysis, the researcher might conclude that as a group, women's favorite dessert is ice cream. However, because women who enjoy ice cream are more likely to enter an ice cream shop than women who do not like ice cream, the study would have a biased sample, and those results might not *generalize* to women as a population.

Many of the principles of good experimental design are focused on reducing bias so that the results will generalize to the population of interest. The ideal study uses a *random sample* of the entire population, so that sampling bias is completely eliminated. However, clinicians and researchers have very little control over whether patients are willing and able to seek treatment, so a true random sample is impossible to attain. For this reason, good outcomes studies follow certain principles, including randomly assigning a certain number of participants into a *control group* (a group that does not receive the tested treatment), against which the treatment sample's outcomes can be compared, and the use of *manualized treatments* (highly specific, structured treatment protocols).

Additionally, when clinicians read outcomes studies for a particular therapeutic technique, they must be able to discern which studies provide the most rigorous tests of the technique's effectiveness. Suppose, for example, a physician would like to learn if a certain drug is effective for lowering levels of LDL cholesterol (sometimes called ''bad'' cholesterol). There is a wide array of methods that the physician could employ to obtain information on the efficacy of the drug, and these methods vary drastically in some very important ways. Using this example, Table 4.1 provides a description of some of the many ways one can measure treatment efficacy, as well as the benefits and drawbacks of using each source of knowledge.

Once a study's methodology has been evaluated against the standards described above, the clinician must be able to understand that study's statistical methods. It would be impossible for this chapter to cover every type of statistic encountered in the treatment outcomes literature. This section therefore will summarize some important statistical concepts in that literature and briefly will describe some that are most frequently used.

A critical concept in understanding data analysis methodology is that of statistical significance, which we mentioned earlier. Statistical significance is the likelihood that a given result would occur by chance. The accepted standard for statistical significance is $p < .05$, which means that there is a less than 5 percent probability that the finding would have occurred by chance alone.

If a researcher were to apply the concepts of sampling methodology and statistical significance to the study of LDL cholesterol levels mentioned above, he or she might proceed as follows. First, the researcher would randomly assign participants to a trial group (participants who receive the drug) or a control group (participants who receive a placebo). Next, participants' LDL levels would be measured before the experiment (the administration of an LDL-reducing drug) and after the experiment. (See Table 4.2.)

Upon examination, the dataset above begins to reveal noticeable patterns. However, if information about height, weight, average daily calorie intake, average cholesterol intake, gender, and activity level from more than 100 participants also was collected and needed to be factored into the drug's effectiveness, it would be difficult to identify significant patterns and trends through simple visual examination of the data. For that reason, mathematical processes (*statistical techniques*) that allow researchers to synthesize data and present findings in meaningful ways are valuable.

Many statistical techniques are descriptive; they describe the sample of individuals studied in some way. Perhaps the most common descriptive statistic is the *mean*, which simply is the average score on a measure of interest for the sample. In the above example, pre-experiment LDL levels

Table 4.1

Hierarchy of Evidence

Evidence	What It Looks Like	Benefits	Drawbacks
Randomized control trial	Researchers randomly select a large number of people, and randomly assign them to one of two groups. One group (the *trial group*) receives drug X. The other group (the *control group*) receives a *placebo*, a pill that looks like drug X but actually has no active ingredients. Researchers measure LDL levels before, during, and after treatment, and then researchers use statistics to compare the differences between groups. Neither the patients nor the researchers measuring LDL levels know whether the patient is receiving the drug or the placebo. This is called a *double-blind* design.	• A control group helps to show that change is due to the drug, not another factor. • Random selection and assignment reduces bias. • A double-blind procedure reduces the *placebo effect*, the tendency for people to get better because they believe a treatment will be effective.	• Conducting a randomized control trial can be costly and time consuming. • In the "real world," most patients know what kind of treatment they are receiving.
Non-randomized study	Researchers select a group of people who use two different doctors (Doc A and Doc B) in a community. During the study, Doc A's patients receive the active drug, and Doc B's patients receive the placebo. Researchers measure LDL levels before, during, and after treatment. After treatment, researchers use statistics to compare the differences between groups.	• This design still tests the hypothesis using a control group.	• Non-random selection and assignment changes in LDL could be due to differences between patients or doctors, instead of differences between the drug and the placebo.

(*Continued*)

Table 4.1
(Continued)

Evidence	What It Looks Like	Benefits	Drawbacks
Expert consensus	At the annual LDL Conference, several internationally recognized doctors meet and discuss their beliefs about the drug. They write a paper, recommending that the drug be used to lower LDL cholesterol.	• Experts are aware of nearly all studies that have been done in the field, historically and recently.	• Expert consensus can become outdated if a new drug is discovered. • Bias is possible.
Literature review	A researcher wants to know if drug X is effective for lowering LDL. Using several different sources, the researcher looks for articles on drug X and writes a paper summarizing her findings.	• Results are integrated across a variety of studies	• Potential for bias is high, because researchers may choose only those studies that support their beliefs.
Anecdotal information	Doc D has been prescribing drug X for several years. He enthusiastically recommends the drug to you, because it is usually effective for his patients.	• You may trust Doc D's professional judgment.	• There is no way to objectively evaluate the drug's effectiveness.

Table 4.2
Sample Data Set

Participant	Group	LDL Level Before Experiment	LDL Level After Experiment	Difference (Before - After)
1	Trial	205	200	5
2	Control	220	220	0
3	Trial	240	220	20
4	Control	230	225	5
5	Trial	245	215	30
6	Control	205	200	5
7	Trial	220	200	20
8	Control	245	240	5
9	Trial	230	205	25
10	Control	240	245	−5

range from 205 to 245 points, and the mean pre-experiment LDL level is 228 points.

Another commonly used descriptive statistic is the standard deviation. The standard deviation describes the overall *distribution* of participants' individual scores in relation to the mean. For example, if one only knew that the mean pre-experiment LDL level was 228 points, it would not be clear whether the pre-experiment LDL scores were closely clustered around the mean (a small standard deviation) or whether there was a wide range of pre-experiment LDL levels (a large standard deviation). In the pre-experiment LDL sample, the standard deviation is 15.13 points.

Correlation is another commonly used statistical technique. Correlation is a way of describing the mathematical relationship between two or more variables. Suppose, using the example of LDL levels, that the researcher wanted to know if the dose of drug X was related to how much LDL levels changed over the course of treatment. With a large enough sample, researchers might administer a wide range of doses to participants and examine the relationship between dose of the drug and the difference between pretreatment and posttreatment LDL levels. Resulting measurement of LDL levels might reveal that, as the dose of drug X increases, the degree of change in LDL levels also increases. This would be called a ''positive correlation,'' which is similar to the correlation one sees between weight and height (i.e., larger individuals tend to be taller and heavier).

Inverse correlations (sometimes called negative correlations) also exist. For example, one might find a negative correlation between grades in

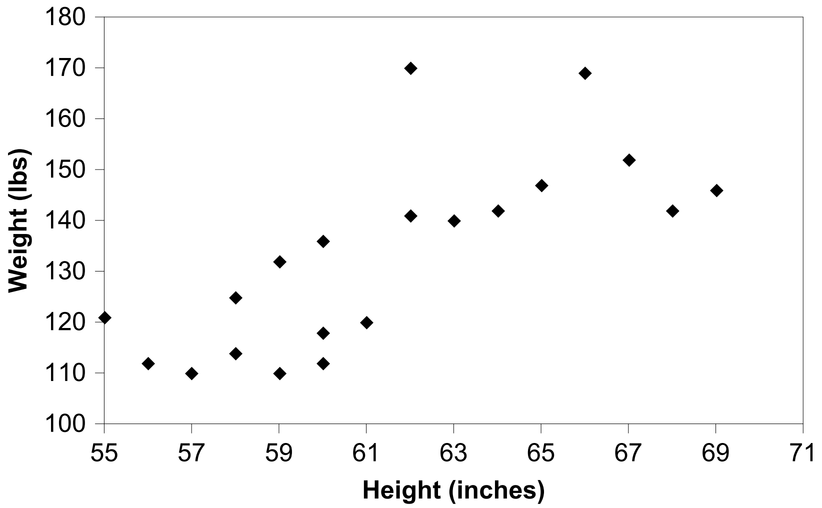

Figure 4.1 Positively Correlated Variables

school and the number of hours of television watched per week by a group of adolescents. In other words, the more television watched, the lower grades are likely to be. Graphs that show this type of relationship between two types of data are called *scatterplots*. Figure 4.1 shows the type of data relationship that would result in a positive correlation (in this case, height and weight). Figure 4.2 shows the type of data relationship that would result in a negative correlation (high school grades and hours of television).

It is important to understand that a correlation between variables does not imply that one variable has caused the change in the other variable. For

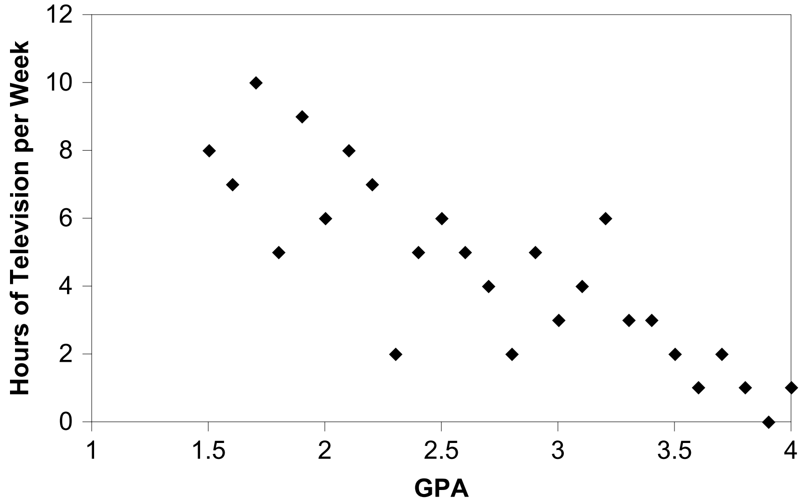

Figure 4.2 Negatively Correlated Variables

example, in most communities in the northeast United States, one probably would find a strong positive correlation between snow shovel purchases and skiing accidents. However, it is highly unlikely that snow shovel sales cause skiing injuries, and vice versa. Snow shovel sales and skiing accidents are *correlated* because they both increase during winter. Beware any study that suggests that simply because two variables are correlated, one must be the cause of the other.

Inferential statistics, those that test whether the treatment is likely to be effective for the population of interest (e.g., children with trauma histories), allow researchers to go beyond describing a sample. One of the basic inferential statistics for treatment outcomes studies is the *paired t-test*. The paired t-test compares the mean and standard deviation of the trial group and the control group and looks for significant differences between those groups. The LDL levels researcher, for example, might look at the *difference scores* (the difference between LDL level before taking drug X and LDL level after taking drug X) for the trial group (those who received drug X) compared to the control group (those who received a placebo). If the differences between the two groups are not statistically significant, chances are, drug X had no effect on LDL levels.

The paired t-test is a useful tool for measuring the efficacy of one type of treatment (in our case, drug X). However, in order to compare the effectiveness of several different types of drugs (drug X, drug Y, and drug Z) for lowering LDL levels, researchers might want to use more advanced statistical methods (such as *analysis of variance [ANOVA]*) in order to reduce the likelihood that significant differences have occurred only by chance. As we stated above, the gold standard of statistical significance is a finding that has a 5 percent or less likelihood of having occurred by chance. Repeated use of the same statistical method (e.g., running multiple paired t-tests to test drug X against drug Y, drug Y against drug Z, and drug Z against drug X) increases the probability that a result could be due to chance alone, rather than to actual differences between the drugs. ANOVA allows researchers to test the effects of several different kinds of treatments, while maintaining a 5 percent or lower probability that the findings have occurred by chance.

The practitioner is likely to encounter many other statistical techniques while delving into the treatment outcomes literature. Though these techniques are beyond the scope of this chapter, there are many resources available for the clinician who would like to build his or her statistical understanding. Some of these are straightforward and geared toward individuals with very little statistical experience (e.g., Norman & Streiner, 2003), whereas other texts are suitable for clinicians who have a solid grounding in basic statistical principles and wish to develop an even more comprehensive understanding of statistical techniques (e.g., Tabachnick & Fidell, 2006).

Perhaps the most comprehensive way to find out if a specific therapeutic technique has good outcomes is to look for a *meta-analysis* of the technique. In meta-analysis, researchers statistically compile the results of a wide array of conceptually related studies. A good meta-analysis uses strict and objective *inclusion criteria*. These criteria are standards that dictate which studies will be included or excluded from the analysis. In a nutshell, meta-analyses compare the *effect sizes*, or degrees of difference between the trial group and the control group, from several different studies in order to evaluate the effectiveness of a treatment. Because of the strict mathematical standards involved, meta-analyses are particularly rigorous and comprehensive, especially when compared to literature reviews (e.g., Rodebaugh, Holaway, & Heimberg, 2004).

As we noted earlier, most treatment outcomes research attempts to answer the question about whether there is a statistically significant difference between pretreatment and posttreatment. However, it is also important to note whether differences are clinically significant. Drug X, for example, may reduce LDL levels by an average of 15 points, and there may be statistically significant differences between the trial group and the control group's postexperiment LDL levels. However, is this change enough to prevent a heart attack? Does a therapeutic technique's statistically significant effectiveness mean that it will improve your clients' quality of life? Clinical significance is a concept that only recently has been embraced by treatment research (Kazdin, 2005, 2007), and some research articles exclude information about clinical significance altogether. This is, in part, because the definition of clinically significant change is difficult to agree upon (e.g., Norman & Streiner, 2003).

APPLYING PSYCHOTHERAPY OUTCOMES RESEARCH

With adequate time and resources, the application of manualized treatments to clinical work would be simple for the individual practitioner. Clinicians would exhaustively review the growing list of evidence-based practices available in print or electronic media; identify approved, manualized practices for each of the diverse presenting problems they encounter; seek training and supervision in each chosen model; and implement the treatment in their work. In just a few short months, clinicians would be able to fully implement each newly learned protocol. In just a few short years, those same clinicians might be considered masters of each new, manualized treatment (Norcross et al., 2006).

Clearly, the exportation of evidence-based practices to real world settings will not happen if such exhaustive work is required of all practitioners. In response to this tension between resource-rich science and resource-poor practice, leading thinkers in behavioral health are beginning to define an alternate path for the practicing clinician. The American Psychological Association's Presidential Task Force on Evidence-Based Practice, for example, citing Sackett (2006), defines evidence-based practice as ''the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients'' (APA Presidential EBP Task Force, 2006, p. 271). The Task Force goes on to explicate evidence-based practice as ''the integration of . . . best available research with clinical expertise in the context of patient characteristics, culture, and preferences'' (APA Presidential EBP Task Force, 2006, p. 273).

The growing body of scientist-researchers who endorse the concept of practice-based evidence might interpret these definitions as follows: Practitioners should regularly consult with the best evidence base available, integrate that evidence with their own expertise and their patients' values, and design assessment and treatment based on that integration. ''Findings are not a replacement for reasoned judgment about what should be applied to a specific case'' (Chorpita et al., 2002; March et al., 2005; Goodheart et al., 2006, p. 9).

Three foundational steps in evidence-based practice must be taken to move toward the integration discussed above. First, clinicians must assess and diagnose to identify target symptoms. Second, clinicians should develop interventions based on the evidence base for those symptoms. Finally, clinicians should evaluate, via multiple domains of data collection, the impact of those interventions on the identified target symptoms (Goodheart et al., 2006). Using these simple steps, clinicians can move through assessment, treatment planning, and intervention using best practice and best available evidence as key guidelines. (See Table 4.3 for case examples of this process.)

Assessment—the identification of presenting problems and their possible etiology—is a fundamental step in this model. Quality clinical care calls for thorough assessment, which allows clinicians to understand clients' struggles and formulate interventions to alleviate those struggles. In the context of evidence-based practice application, thorough assessment also allows the practitioner to construct a specific, researchable set of target concerns to address with evidence-based treatment components (March et al., 2005; Mash, 2005).

Evidence-based assessment practices, then, can and should be applied at the start of treatment. Standardized measures for presenting problems exist

Table 4.3

Case Examples of Evidence-Based Practice Integration

Presenting Problems/Symptoms	8-year-old boy with oppositional, aggressive behaviors	13-year-old girl w/disordered eating
Assessment/Diagnosis (Identify and prioritize target symptoms)	BASC and clinical interviews administered to youth, parents, and teacher. All reveal elevated oppositional behaviors in all contexts, poor social skills at school.	Comprehensive, multidisciplinary assessment of risk, physical health, eating behaviors, psychosocial needs, and stressors yield pattern of binge-eating of junk foods in response to emotional stressors.
Results of Literature Review (Catalogue-supported strategies for target symptoms and broader interventive or preventive approaches)	Parent training in behavior management and/or in collaborative problem solving is treatment of choice; social skills training has some support.	Evidence-based guided self-help programs strongly supported. Emotion recognitition and coping skills have some support, CBT techniques for bulimia also indicated. Nonresponsive clients may be trialed on antidepressant medication with some positive effect.
Intervention Strategies Identified	Train parents in structured behavior management protocol; refer youth for social skills group in school.	Begin guided self-help program, include emotion-coping strategies. Refer for physical and nutritional evaluation/counseling.
Monitoring Strategies	Reinterview youth and collaterals; readminister BASC q 30 days.	Comprehensive reassessment q 30 days.
Response to Outcomes	Reassessment reveals reduction in oppositional behaviors in all contexts. No improvement in social skills but good engagement in group. Clinician continues with reinforcement and practice of behavior management strategies.	Reassessment reveals limited reduction in binge eating from all sources. Reinterview of youth regarding coping strategies reveals numbing sensation before binge behaviors. Continue self-help program, stop emotion-coping strategies, and begin building emotion-identification skills.

Table 4.4
Evidence-Based Practice Application Questions*

What target symptom(s) are present?
What is the key problem or symptom to address?
What research population (e.g., young children with oppositional behaviors) is represented by the key problem or symptom?
What treatments have been tried and with what outcomes?
What outcomes would all interested parties like to achieve?
What evidence-based treatments or components are available for the target symptoms and feasible for the clinician/context?

*Adapted from March et al., 2005.

for many typically presenting concerns in children and adolescents (Sattler & Hoge, 2006). Additionally, empirically informed practice guidelines encourage the use of multiple methods of assessment. Information should be collected using appropriate standardized measures, clinical interview, and input from clients and collateral informants. In the case of children and adolescents, information on internal experience and contextual functioning is critical to an accurate diagnostic formulation (Nezu & Maguth Nezu, 2008; Steele, Elkin, & Roberts, 2007).

The application of evidence to clinical practice can be structured by the use of the questions in Table 4.4. These questions, adapted from the Duke Pediatric Psychiatry Evidence-Based Medicine Seminar Team (March et al., 2005) for use in community-based mental health programs, will guide each step of assessment and treatment planning, systematically, in the application of evidence-based thinking. Importantly, use of the questions also will highlight collaborative goal-setting and treatment identification, and thus will allow clinicians to begin with the patient and ask, ''What research evidence will help achieve the best outcome for this individual?'' (APA Presidential EBP Task Force, 2006).

Identification and prioritization of key target symptoms (or diagnoses) leads to a planful search of the available literature. Clinicians need not discard the idea of consulting the evidence base due to a lack of the time or skill to do a thorough literature search (see Table 4.5). Practice guidelines from credible professional associations, for example, are readily available for many diagnoses and can be consulted quickly in order to rule out contraindicated treatments and identify best treatment practices (O'Donohue & Fisher, 2006). With a bit more time and effort, quality edited books on evidence-based practice for children and adolescents can be reviewed for applicable treatments and intervention components. Additionally, several

Table 4.5

Hierarchy of Search Strategies by Level of Detail and Difficulty

Source	Strategies
Practice Guidelines by Credible Professional Organizations	Identify available guidelines for all identified symptoms Review guidelines, catalogue indications and contraindications Fine-tune existing care accordingly
Edited Books on Evidence-Based Practice	Choose several books from credible sources Review all chapters applicable to treatment questions Catalogue common components of intervention Identify components feasible to context and client Implement and monitor interventions
Web-Based-Lists of Approved Evidence-Based Practices	Search lists for approved treatments for target symptoms Catalogue common components of intervention Identify components feasible to context and client Implement and monitor interventions
Detailed Search of Academic Literature	Seek librarian assistance Use defined search terms around age and symptoms Evaluate scientific merit Catalogue common components of intervention Identify components feasible to context and client Implement and monitor interventions

easy-to-use and regularly updated web sites from trusted sources are available on the Internet; these provide lists, with brief descriptions and source citations, of practices considered evidence based for children and adolescents. In edited books and web sites from credible sources, the quality of evidence has been evaluated by experts in the field. A list of many of these resources is provided at the end of this chapter, in the References section, and in Appendix A.

The gold standard for reviewing evidence (and also the most labor intensive), however, is a thorough review of the treatment research literature. Web-based search engines generally are available for free use in regional library systems; librarians can offer assistance in using these search engines effectively. For a brief but thorough review of how to understand and use search terms, see March et al., 2005.

Regardless of the chosen resource, the reviewing clinician should attempt to identify studies or guidelines that (a) address components of behavior that must be treated with the target client and (b) have (or are guided by studies that have) strong empirical support (see the first section of this chapter for guidelines on evaluating research quality). Clinicians are not necessarily searching, in this review, for a single, manualized approach, but are examining the evidence to find repeated quality support for treatment strategies.

Manualized treatments or treatment approaches that share most strategies and are strongly similar in theoretical underpinnings can be considered the same, particularly if they fail to outperform each other in randomized, controlled trials. Intervention strategies common to those approaches and categorically supported by evidence are the variables of interest in each review and should be catalogued (Chorpita et al., 2002). For example, three chapters or articles on effective treatment of bulimia nervosa might offer varying treatment calendars, but may share the use of cognitive behavioral strategies to increase emotional coping skills and the use of interpersonal therapy strategies to foster the adoption of those skills in the patient.

The clinician now should examine the feasibility of catalogued strategies in the actual practice context. For example, if cognitive behavioral strategies are strongly indicated but family therapy also has support, the clinician with no cognitive behavioral training or experience but a solid background in family therapy might integrate family therapy into treatment immediately and then seek training and supervision in cognitive behavioral strategies. Parent training, which is strongly indicated for treatment of childhood externalizing disorders, might give pause to the clinician who habitually works with parents only as collaterals. In this case, the clinician must critically examine whether skill set or preferences are at the root of this hesitation. This practitioner-driven examination will yield a list of strategies for immediate implementation, a list of strategies to implement with training and/or supervision, and a list of treatments that might lead to an outside referral.

The evidence-based strategies compiled by the clinician next should be modified for the care of the individual patient. Because intervention strategies are most likely to work when they respond to the patient as a whole, including that person's strengths, personality, preferences, and sociocultural context, each individual patient must be consulted during every phase of the treatment planning and implementation process (APA Presidential EBP Task Force, 2006; March et al., 2005; Goodheart et al., 2006; Wampold, 2001). Disparate patient variables (including values, beliefs, worldview, goals, and culture) impact outcomes, and clinicians' choice of strategies also must take key patient variables into account (Lau, 2006; Whaley & Davis, 2007). An inner-city family with limited resources might not be able to coordinate tangible material rewards for an intervention for their oppositional child, for example, and might need adaptation for this component of treatment in order to succeed. An orthodox Christian adolescent with bulimia nervosa might not be accepting of mindfulness meditation techniques to cope with emotional triggers, but might accept meditational prayer as a cultural adaptation.

In the case of child and adolescent psychotherapy, developmental considerations also are key components of patient characteristics and context. The treatment of youth with mental health issues is inherently complex and is impacted dynamically by complex issues around treatment engagement, context (e.g., family life, school functioning), and frequent comorbidity (Weisz, Jensen-Doss, & Hawley, 2006). The development of social and emotional competence is an ongoing task of childhood and adolescence (Suveg et al., 2007), and addressing impairments in this development must be integrated into the treatment of any pediatric psychiatric disorder. The success of social skills training as an adjunct to parent training for the treatment of childhood externalizing disorders is an example of this integration, as it allows the child patient to develop age-appropriate skills that may have been impaired over the course of the behavioral disturbance.

Issues regarding comorbidity must also be integrated into the treatment plan. Most patients in real world settings do not present with pure diagnostic categories, and children who are referred for behavioral health treatment are particularly likely to present with more than one diagnosis. Burgeoning evidence and current expert consensus suggest that treating and alleviating one set of symptoms in patients with comorbidity will have a positive impact on the patient's functioning overall (Norcross et al., 2006; Piotrowski, 2007). Additionally, the superiority of evidence-based approaches over usual care has not been found to be affected by the degree of comorbidity in the sample being studied (see, for example, Weisz et al., 2006).

Because collaboratively set treatment goals and priorities that place client needs and perspectives first have been found to lead to more effective treatment, the most well-supported approach to address comorbidity would be the use of collaborative goal setting and clinical judgment to triage care. What problem or symptom does the client (or the clients' parents and teachers) have motivation to address (Waters & Lawrence, 1993)? What available, proven practices are available for this client's presenting problems? What symptoms/problems is the clinician best qualified to treat? What treatment strategies does the patient feel hopeful about? What treatment strategies does the patient (or patient's primary caregivers) feel skeptical about? Transparent discussion of these questions, at developmentally appropriate levels with children and adolescents, and at adult levels with collaterals, will enrich the treatment plan.

At this stage, clinicians will have developed a treatment plan based on a careful examination of the evidence base and driven by a cogent treatment rationale. The application of intervention strategies now begins and should be guided by the concept of practice-based evidence. This approach calls for the use of ongoing measurement of actual patient outcomes to make decisions about effective interventions. (Bergner, 2005; Goodheart et al., 2006).

As each clinical strategy is implemented, patient response (subjective and objective) is measured, and the strategy is altered or reinforced depending on that response. Patient response, also known as treatment outcome, should be measured using standardized measures, information collected in session, and culturally or contextually derived knowledge (Bergner, 2005).

Monitoring of response should be ongoing and might include the regular administration of a standardized behavioral checklist, simple, weekly check-ins with child, and context about change or stasis in functioning, symptom distress, and relationships (Okiishi et al., 2006). From each source of information, data is collected to support the hypothesis that a planned intervention is having its intended impact. If data fail to support this hypothesis (i.e., the patient fails to improve), treatment planning must be revisited. If data reflect improvement, treatment as planned can continue apace.

If, for example, a preteen with binge eating presents for treatment and is found, upon assessment, to have poor emotional coping skills, the treating clinician might begin teaching empirically supported emotion-coping strategies such as progressive relaxation, mindfulness techniques, or visualization. The clinician might then inquire, prior to beginning subsequent sessions, as to the effectiveness of these strategies in the preteen's day-to-day life. If the child and collaterals endorse a reduction in binge eating after using these strategies, strategies should be reviewed and reinforced before moving on in treatment. If, however, the child reports feeling numb prior to binge eating and unable to effect the strategies, the clinician might modify the intervention to address the numbness and teach the child to identify emotions for several sessions before returning to emotion-coping interventions.

Although the menu of evidence-based treatment approaches for children and adolescents expands each year, evidence will not always be available to target every practice need. However, the application of evidence-based strategies is possible even still. In the absence of directly applicable treatment findings, clinicians can turn to the evidence base on complexity (see the previous discussion of comorbidity), apply interventions that are not diagnosis specific but have proven effective for improving functioning for youth in general (Burns, 2003), and attend to the quality and strength of the therapeutic relationship (Kazdin & Nock, 2003; Wampold, 2001). Treatment planning supported by a cogent rationale, interventions applied with skepticism and careful, objective monitoring of patient response is, in and of itself, an evidence-based strategy.

CONDUCTING PSYCHOTHERAPY OUTCOMES STUDIES

It is beyond the scope of this chapter to prepare the average psychotherapy practitioner to conduct quality outcomes research. However, some clinicians find that the application of evidence-based thinking to practice leads to heightened interest in clinical research. Most clinicians will find value in evaluating outcomes as a whole in their individual practice. Toward that end, this section offers a brief outline of key points of consideration in the conduct of outcomes research. The authors encourage those readers interested in deepening their knowledge and skill to access more in-depth but user-friendly resources on research (e.g., Nezu & Maguth Nezu, 2008; Norman & Streiner, 2008; Wholey, Hatry, & Newcomer, 2004), which are listed at the end of this chapter in the References section and in Appendix A.

Consider the ethical issues involved in conducting research as you design your study. Research design must balance the needs of science with the respect of individuals being studied. All clinical work, including research, calls for the protection of clients' rights as a first priority. Similar to the ethical considerations of practice, clinical research requires the clinician to obtain informed consent, ensure confidentiality, and identify and address conflicts of interest. In addition, researching clinicians also must weigh the potential risks and benefits of participation to clients, engage in careful debriefing following the study, and allow clients to refuse participation without jeopardizing the quality of treatment or the therapeutic relationship. Clinical research is a complex undertaking. It would be unethical to represent this paragraph as a complete summary of all the ethical issues that must be considered when undertaking clinical research. Clinicians should refer to well-regarded publications on the conduct of research with human participants (e.g., Sales & Folkman, 2000).

Consider your question. There are two primary questions in outcomes research by the practitioner. If a treatment is new or untested, we ask, "Does this type of intervention work?" For example, a clinician who conducts social skills training groups for preteens might ask, "Does participation in these groups lead to significantly more improvement in social skills than would happen developmentally in nonparticipant controls?" This question is one of *treatment efficacy*. A more common question is that of *treatment effectiveness*. We seek effectiveness data once a treatment's efficacy has already been proven in a highly controlled university environment. In this case, we ask, ''Does this type of therapy work in this setting or with these patients?'' If social skills therapy groups have proven efficacious with preteens in university-based trials, the private practitioner might ask, ''Does participation in social skills groups by the unique group of children in my practice lead to significant improvements in social skills?''

Carefully design your study before beginning data collection. It is important that data collected both link to your question and can be analyzed by the statistical method necessary to rule out or support your hypothesis. If a clinician is attempting to measure improvements in school behavior resulting from a given intervention, baseline (preintervention) and posttreatment measures of actual behavior in school must be administered, and statistical tests allowing for dependent samples must be used in analysis. It also is important to address issues of possible bias during the study design phase. For example, good outcomes studies ensure that when two types of therapy are compared (for instance, comparing cognitive behavioral therapy and interpersonal therapy for the treatment of childhood trauma), the clinicians performing the therapy closely follow the guidelines set forth in the treatment manuals. By closely following the treatment manuals for each type of therapy, the clinician ensures that he or she is not inadvertently sabotaging the type of therapy that he or she believes to be less effective.

Design your study while following the principles of good experiment design. These basic principles, outlined earlier in this chapter, should be followed to the best of the clinician-researcher's ability. A randomized control trial will be difficult to achieve for most practicing clinicians, but control or comparison groups should be incorporated when feasible.

Maintain accurate, well-organized records of all aspects of the research. Data should be well organized, clearly labeled, and maintained in a confidential and protected location. The clinician-researcher should also be sure to take careful notes on methodology (including inclusion criteria for participants) and document therapist action and nonaction (Sternberg, 2000). High-quality interpretation of treatment outcomes research must include careful consideration of the specifics of that research, and it is very easy for busy clinicians and researchers to forget details as a study proceeds.

Do not fish for findings in the analysis phase. The researcher should attempt to remain true to the questions and analyses originally identified in a study's design. As the data are analyzed, the researcher must ask objectively, ''Do the data support my hypothesis that this treatment works or works with this population?'' Researchers should not give in to the temptation to conduct enough separate statistical analyses to create significance. Should the clinician find no statistical relation between treatment applied and anxiety symptom improvement, for example, he or she may be tempted (after so much hard work) to double back and ask qualitatively different questions with the same data (e.g., ''Does the quality of a child's play improve as a result of this treatment?''). However, because the outcomes data were not collected to measure play quality, this new question is unlikely to yield scientifically sound results and will do nothing to help clients (Norman & Streiner, 2008).

Objectively and thoroughly examine and interpret your data. Although the researcher should make conclusions based on significant findings, he or she also must look for alternative explanations for your findings. Improvement in social skills, for example, might happen developmentally, at a statistically significant level, between the ages of 8 and 13. Interpretation of a study's findings also should extend to the identification of treatment-related actions that might arise from those findings.

Although the busy clinician may feel overwhelmed by the idea of mastering diverse evidence-based practices, using these practices as a guide for intervention can be done with moderate resources and effort. Incorporating best available evidence into treatment can be done in a clinically flexible way that engages clinical judgment and expertise, and can serve only to benefit individuals in our care.

APPENDIX A: ELECTRONIC MEDIA RESOURCES

American Academy of Child and Adolescent Psychiatry practice parameters: http://www.aacap.org/page.ww?name=Physicians+and+Allied+Professionals&section=Physicians+and+Allied+Professionals
Attention-Deficit Disorders: http://www.chadd.org/
Autism Speaks: http://www.autismspeaks.org/
Bipolar Disorder: http://www.bpkids.org/site/PageServer
California Evidence-Based Clearinghouse for Child Welfare: http://www.cachildwelfareclearinghouse.org
Center for Excellence in Early Childhood Education: http://www.childsteps.org/

Child Care and Education Research Connections: http://www.childcareresearch.org

Child Steps (comprehensive reviews of EBPs for children and adolescents): http://www.childsteps.org/

Child Welfare Information Gateway: http://www.childwelfare.gov/pubs/usermanual.cfm

Clinical Evidence Online (searches for and summarizes the best clinical evidence in answer to key clinical questions): http://www.clinicalevidence.com

The Cochrane Collaboration (provides a broad range of information on evidence in health and behavioral health care): http://www.cochrane.org/#

Committee on Science and Practice of the Society of Clinical Psychology of the American Psychological Association (list of various psychotherapies that have met basic scientific standards for effectiveness): http://www.apa.org/divisions/div12/rev_est/

Culturally Competent Care: http://www.massgeneral.org/interpreters/cultural.asp

Database of Abstracts of Reviews of Effectiveness (DARE): http://www.york.ac.uk/inst/crd/crddatabases.htm

Duke University Evidence-Based Medicine Tutorial (summary of introductory ideas about the application of EBP): http://www.hsl.unc/edu/Services/Tutorials/EBM/index.htm

Duke University Evidence-Based Medicine Toolkit (advanced information and links for the application of EBM): http://www.mclibrary/duke.edu/training/pdaformat/ebm.html

Duke University Medical Center Library Online EBM page (assistance with understanding and teaching EBM): http://www.mclibrary.duke.edu/subject/ebm

Dynamed (surveys and summarizes original empirical treatment findings): http://www.dynamicmedical.com

Early childhood intervention/prevention site: http://www.recognitionandresponse .org/

Educational practices: http://www.whatworks.ed.gov/

Educational practices: http://www.interventioncentral.org/

Emerging Strategies in Evaluating Child and Family Services, Harvard Family Research Project: http://www.gse.harvard.edu/~hfrp/

Evidence-Based Health Resources (links to reliable sources of evidence in health and behavioral health care): http://www.libraries.wright.-edu/services/researchguides.med/ebm.html

Evidence-Based Medicine (accesses additional resource and tutorial links and provides a summary of EBM): http://www.childrensdayton.org/Residents/EBM_Background_Info/Intro_to_EBM.pdf

Evidence-Based Mental Health Online (alerts users to advances in all areas of EBP in mental health): htttp://ebmh.bmj.com/info/about.dtl

Evidence-Based Practice: http://www.findingevidence.com/?p=139

Hawaii Task Force via Hawaii State Mental Health (reviews interventions and services that research has shown to be most effective in addressing severe behavioral and emotional challenges of children and youth): http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html

How to Use a Clinical Practice Guideline (excellent site for understanding, evaluating, and applying practice parameters and guidelines. Medically oriented, but easy to apply to mental health services): http://www.cche.net/usersguides/guideline.asp#I1

InfoRetriever (searches primary and secondary sources and provides pithy summaries of the evidence base): http://www.infopoems.com

Mass General Hospital School Psychiatry site (includes a particularly good list of screening tools): http://www.massgeneral.org/school psychiatry/index.asp

National Association for the Dually Diagnosed: https://www.thenadd.org/index.shtml

National Association of Statement Mental Health Program Directors Research Institute (provides a matrix of empirically supported therapies for children, among other resources): http://www.nri-inc.org/projects/CMHQA/matrix.cfm

National Mental Health Information Center (SAMSHA): http://mentalhealth.samhsa.gov/

National Center for Mental Health & Juvenile Justice: http://www.ncmhjj.com/training/default.asp

National Child Traumatic Stress Network (SAMSHA): http://www.nctsnet.org/nccts/nav.do?pid=hom_main

National Guideline Clearinghouse (provides summaries of various practice parameters and treatment guidelines): http://www.guideline.gov

National Registry of Evidence-Based Practices & Programs (SAMSHA): http://nrepp.samhsa.gov/

National Technical Assistance Center for Children's Mental Health/Georgetown University (various topics, foci on evaluation, EBP, systems of care, early childhood mental health): http://www.gucchd.georgetown.edu/programs/ta_center/index.html

NYU Child Study Center (various topics, excellent resource for consumers and clinicians): http://www.aboutourkids.org/

Obsessive Compulsive Disorder in children, adolescents, and adults: http://www.ocfoundation.org/

OCFS Promising & Best Practices (child welfare): http://www.ocfs.state.ny.us/main/sppd/eff_practices/

Orelena Hawks Puckett Institute's Center for Innovative and Promising Practices (summarizes research on the development and use of innovative and promising family support, early intervention, childhood education, and related practices for promoting and enhancing child, parent, and family competence): http://www.puckett.org

OVID (contains Medline, which offers full text articles and abstracts, and allows access to the ACP Journal Club and the Cochrane Library): http://www.ovid.com

Patient Care (links to a variety of sites, including those that identify evidence-based practices): http://www.myhq.com/public/a/l/alper

PDxMD (searches and links to primary and secondary sources and provides diagnostic and treatment summaries): http://www.pdxmd.com

Practice-based evidence (review and resources): http://www.practicebasedevidence.com/

PsychInfo (published by the American Psychological Association and provides abstracts of APA journal articles): http://www.apa.org/psychinfo

PubMed (the search engine that allows search of the National Library of Medicine's journal library): http://www.pubmed.gov. A tutorial for using PubMed also is available at the following site: http://www.nlm.nih.gov/bsd/disted/pubmedtutorial/

Resource for Advancing Children's Health (*REACH*) (identifies and validates the highest quality scientific findings in children's behavioral health, adapts interventions for real-world settings, and provides training and support): http://www.reachinstitute.net/REACH_Institute-ChildAdolescentMentalHealth.html

Research and Training Center on Early Childhood Development (provides synthesis on research in early childhood intervention, with special attention to families and social support.): http://www.researchtopractice.info/activities.php

Spanish Family Assessment: http://www.nfpn.org/store/category_id,8/

Tufts Child & Family web (leads to many web-based sites on varying topics): http://www.cfw.tufts.edu/category/1.htm

Turning Research into Practice (provides summaries of multiple reliable/quality sources of evidence-based treatment information): http://www.tripdatabase.com

U.S. Department of Health and Human Services, National Child Care Information Center: http://nccic.org/

SAMSHA (allows clinicians to search by age group for evidence-based practices): http://www.samhsa.gov/ebpWebguide/index.asp

University of South Florida Research & Training Center for Children's Mental Health (includes good information on cultural competence and systems of care): http://rtckids.fmhi.usf.edu/cssi/

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CHAPTER 5

Play Therapy Research: History and Current Empirical Support

JENNIFER BAGGERLY

PLAY THERAPY RESEARCH: HISTORY AND CURRENT EMPIRICAL SUPPORT

Critics have stated play therapy has limited empirical support (Cohen, Mannarino, & Rogal, 2001). Yet, play therapists have touted the long, rich history of their discipline and highlighted numerous research studies demonstrating the effectiveness of play therapy (Ray, Bratton, Rhine, & Jones, 2001). The purpose of this chapter is to (a) discuss the philosophical and historical foundation for play therapy research, (b) identify the breadth of play therapy research, (c) illuminate meta-analysis findings, (d) describe recent play therapy and filial therapy research studies, and (e) suggest future research directions.

Before beginning this discussion, it is necessary to define two terms: play therapy and research. According to the Association for Play Therapy (APT) (2008), play therapy is defined as:

> the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development. (p. 2)

This broad definition of play therapy includes varying theoretical approaches including prescriptive play therapy (Schaefer, 2003), child-centered play therapy (Landreth, 2002), and cognitive behavioral play therapy

(Knell, 2003). However, APT's definition distinguishes play therapy from other types of children's mental health interventions that use play but are implemented by practitioners who do not identify as ''trained play therapists.''

In general, the noun *research* has been defined as ''studious inquiry or examination; investigation or experimentation aimed at the discovery and interpretation of facts, revision of accepted theories or laws in the light of new facts, or practical application of such new or revised theories or laws'' (Merriam-Webster, 2008). This broad definition of research accommodates the changing research standards during the last century.

PHILOSOPHICAL AND HISTORICAL FOUNDATION FOR PLAY THERAPY RESEARCH

Over the last 100 years, there have been changing philosophical inquiries for truth as well as a variety of acceptable research methodologies. Scientific inquiry has had three major philosophical paradigms (Brown, Crawford, & Hicks, 2003). The first philosophical paradigm is positivism, the belief that there is a real truth that can be known through our senses (Brown, Crawford, & Hicks, 2003). Researchers advocating positivism attempt to prove the best approach. Historically, mental health researchers conducted case analysis to prove their approach was the best (Lawrence, 1943). Currently, randomized controlled clinical trials are used to determine the best practice in alleviating a particular symptom such as depression (Brown et al., 2003).

The second philosophical paradigm is realism, the belief that only a deep generative structure to the world can be found (Brown et al., 2003). Researchers advocating realism seek a common thread or active ingredients. For example, randomized comparison studies with and without a particular feature may be used to determine the active ingredient in a variety of approaches. The third philosophical paradigm is postmodernism, the belief that there is no objective understanding and that deconstruction must occur to identify a variety of meanings (Brown et al., 2003). Researchers advocating postmodernism seek how truth is constructed for individuals in a particular sociopolitical cultural linguistic setting. For example, qualitative studies of clients' perceptions may be used to determine how the counseling process was helpful.

Although each philosophical paradigm advocates a different research approach, many mental health professionals recognized that the collective wisdom from all research studies provides empirical support that can guide clinical practice. The American Psychological Association Council of Representatives stated ''a sizeable body of evidence drawn from a variety of research designs and methodologies attests to the effectiveness of psychological practices'' (APA, 2005, p. 1). Similarly, Lines (2001) asserts that both positivistic quantitative and postmodern qualitative studies are needed in health professions. ''We need to participate in a critical discussion of evidence-based practice, but one that is informed by the complex philosophical issues that permeate all our sociocultural and linguistic practices'' (Lines, 2001, p. 174). Thus, a wide range of research methodologies over the past 100 years have contributed to empirical support in child psychology and subsequently play therapy.

In the early 1900s, child psychology research was a slowly emerging discipline with early studies based on observations of single children (Lawrence, 1943). This slow but cumulative development of research later provided the foundation for child guidance clinics in the 1940s (Lawrence, 1943). In the new millennium, child psychology research is considered to be well established with randomized, well-controlled clinical trials as the gold standard (Cohen, Berliner, & March, 2000; Saunders, Berliner, & Hanson, 2004). Like child psychology research, play therapy research began with clinical observations, which laid the foundation for subsequent experimental studies.

Beginning Clinical Observations

As early as the 1920s, play therapy research emerged via published clinical observations of single children by several renowned play therapists. In a series of journal articles from 1921 through 1945, Melanie Klein (1948) gave detailed psychoanalytic clinical accounts of how she used play techniques to interpret the fantasies of children. Anna Freud (1946) also published a series of lectures from 1926 to 1945 that described her accounts of using play to build relationships with children in psychoanalysis. At that time, publishing this type of case analysis was the norm in psychoanalytic research (Lawrence, 1943).

In the same era, Virginia Axline (1947) published child-centered play therapy transcripts and her analysis of the effectiveness of her approach. Axline's intent to conduct research is demonstrated in her annotated case of group play therapy with boys in foster care. She stated:

> An analysis of the therapist's responses illustrates several points. Out of thirty-three responses, twenty of them were directed toward Ernest, six were in responses to Saul, three responses were to Timmy and Buddy, while

> Bobby received only one response. This is a very uneven scattering of responses. Too many of the therapist's responses in the first contact are interpretive and go beyond the feeling that the boys express. . . . An analysis of the play activities shows that the boys included reactions to home and to parents, desires to be a baby, and aggressive reaction in their play. (pp. 217–218)

Axline was evaluating her own fidelity to her child-centered approach as well as monitoring the boys' progression in play themes and behavior. These three pioneering play therapists provided the foundation and impetus for subsequent play therapy research throughout the rest of the century.

BREADTH OF PLAY THERAPY RESEARCH 1942–1999

The breadth of play therapy research prior to the new millennium was highlighted by Bratton and Ray's (2000) review of 82 play therapy experimental research studies from 1942 to 1999. They noted that seven play therapy research studies in the 1940s, 11 in the 1950s, and six in the 1960s focused mainly on intelligence and school achievement. In contrast, 23 research studies in the 1970s and 16 in the 1980s focused on social adjustment and self-concept issues. In the 1990s, 17 studies focused on ''societal ills such as domestic violence, divorce, drug abuse, and sexual abuse as well as diagnoses such as attention deficit, depression, and conduct disorder'' (Bratton & Ray, 2000, p. 49). The studies they reviewed represent the positivism philosophy as most compared play therapy with a control. Results of these 82 studies suggest efficacy of play therapy with various presenting problems. However, several limits in research study designs prevented the establishment of play therapy as ''the'' most effective approach (from a positivism philosophy). Bratton and Ray (2000) stated that play therapy research limits can be overcome by increasing study sample sizes, comparing play therapy to other interventions, using common standardized assessments for specific symptoms, and specifying treatment procedures.

These initial concerns of play therapy research should be considered in light of the developmental stage of the discipline. Child psychology research began in the early 1900s, while play therapy research began in the 1920s, resulting in a 20-year difference in the disciplines. The first psychology professional organization dealing specifically with child research, the American Psychological Association Division 7, was established in 1945, while the first play therapy professional organization, the Association for Play Therapy, was established in 1982. Thus, the discipline of play therapy could be conceived as younger than the discipline of child psychology. Hence, play therapy may be following the same trajectory in establishing research support as did child psychology. Even child psychology researchers have noted that there is often a lag between clinical use of a treatment and extensive empirical testing (Saunders et al., 2004).

Another factor in the perceived play therapy research lag appears to be an emerging postmodern qualitative approach rather than solely a positivism quantitative approach. From 2002 to 2004, only 9 percent of the International Journal of Play Therapy research articles were qualitative in nature. Yet, from 2005 to 2007, 26 percent were qualitative in nature, representing a 34 percent increase in this postmodern approach. Examples of such studies include ''A qualitative study of filial therapy: parents' voices'' (Foley, Higdon, & White, 2006) and ''Elementary school children's perceptions of play therapy in school settings'' (Green & Christensen, 2006). This philosophical shift to postmodern approaches in research may be in response to a changing sociopolitical world in which culturally and linguistically diverse clients are being empowered to help create a more responsive mental health delivery system (Brown et al., 2003; O'Connor, 2005).

Along with honoring the contributions of postmodern qualitative studies, APT continues to encourage more quantitative studies. The APT (2007) research committee established a strategy to ''encourage researchers to conduct well-designed experimental psychotherapy outcome studies that examine benefits from treatment as compared to either a comparison treatment and/or a control group'' (p. 3). As will be discussed below, researchers in play therapy certainly heeded the challenge to generate more rigorous research studies (Ray, 2006).

Play Therapy Meta-Analysis

At the beginning of the new millennium, one of the most helpful play therapy studies was Bratton, Ray, Rhine, and Jones' (2005) meta-analysis. They combined the results of 93 individual play therapy and filial therapy studies conducted between 1953 and 2000. A meta-analysis determines the amount of change for individuals in the treatment groups versus those in control groups and then averages the amount of change across the studies (Bratton et al., 2005). These researchers found the effect size (i.e., average amount of change in standard deviation units) for all 93 play therapy and filial therapy studies was $d = .8$, indicating a large treatment effect. When they compared characteristics of these studies, they found filial therapy by parents had a larger treatment effect (*d* = 1.15) than did play therapy by therapists (*d* = .73). In addition, humanistic-nondirective approaches had a larger treatment effect (*d* = .92) than did nonhumanistic-directive approaches (*d* = .71). These researchers concluded ''the overall meta-analytic results establish play therapy is a statistically viable intervention'' (Bratton et al., 2005, p. 385). Future meta-analysis of play therapy research studies published in the new millennium may add further support for the effectiveness of play therapy since play therapy researchers are using more stringent standards.

EMPIRICAL SUPPORT IN THE NEW MILLENNIUM

CURRENT STANDARDS

In the current era of shrinking economic resources, insurance companies, mental health organizations, and researchers have attempted to identify the best treatments in order to conserve resources. Within this positivism paradigm, organizations such as the American Psychological Association Division 12, Science and Practice Committee, defined empirically supported treatments (EST) or evidence-based practices (EBP) based on the gold standard research design used by pharmaceutical companies to test for effective medications. These same standards are also used by the Society of Clinical Child and Adolescent Psychology (Division 53, American Psychological Association) (SCCAP, n.d.) for evidence-based mental health treatments for children and adolescents. These standards are as follows.

Best Support (''Well-Established Treatments'')

I. At least two good between-group design experiments demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group).

OR

II. A large series of single case design experiments ($n \geq 9$) demonstrating efficacy. These experiments must have:
   a. Used good experimental designs.
   b. Compared the intervention to another treatment as in I.a.

AND

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals.

IV. Characteristics of the client samples must be clearly specified.
V. Effects must have been demonstrated by at least two different investigators or teams of investigators.

Promising (“Probably Efficacious Treatments”)

I. Two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group. *Manuals, specification of sample, and independent investigators are not required.*

OR

II. One between-group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group).

OR

III. A small series of single-case design experiments ($n \geq 3$) with clear specification of group, use of manuals, good experimental designs, and compared the intervention to pill or psychological placebo or to another treatment.

Of course, these EBP criteria are considered controversial by researchers within the realism and postmodern paradigms who believe just because a treatment does not meet these criteria does not mean it is not just as effective. For example, Wampold (2001) contends:

> “the conceptual basis of the EST movement is embedded in the medical model of psychotherapy and thus favors treatments more closely aligned with the medical model, such as behavioral and cognitive treatments . . . giving primacy to an EST ignores the scientific finding that all treatments studied appear to be uniformly beneficial as long as they are intended to be therapeutic. (pp. 215–216)

Nevertheless since positivism is a prominent paradigm, the question arises does play therapy meet the EBP criteria to be either a “well-established treatment” or a “probably efficacious treatment”? In order to answer this question, play therapy research studies will be reviewed based on the following criteria: (1) published in a professional journal since 2000, (2) comparison or control group with a sample size of 20 or more, (3) treatment and statistical methods described in detail, and

(4) statistically significant impact on children, parents, or teachers. Based on these criteria, an exhaustive search revealed eight play therapy and eight filial therapy research studies that meet these criteria. Studies will be presented in chronological order of publication date.

PLAY THERAPY RESEARCH

Interestingly, all the play therapy research studies that met the above stated criteria happened to be Child-Centered Play Therapy. According to Landreth (2002), Child-Centered Play Therapy (CCPT) is defined as ''a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development'' (p. 16). Standard CCPT procedures including allowing the child to lead the play, tracking play behavior, reflecting feelings and content, returning responsibility, encouraging, building self-esteem, facilitating understanding, and therapeutic limit setting were implemented (Landreth, 2002). The following experimental and control or comparison group research studies demonstrated the effectiveness of CCPT in decreasing children's symptoms.

Fall, Navelski, and Welch (2002) conducted a pretest posttest treatment control group study with children identified for special education services. Sixty-six children ages 6 to 10 years old who received special education services were randomly assigned to either the treatment group receiving six 30-minute individual child-centered play therapy sessions at their school or the control group. Pre- and posttreatment testing was conducted using the *Self-Efficacy Scale for Children* and the *Conners' Teacher Rating Scale*. Results show children in the CCPT group had significant decreases in problem classroom behaviors and social problems, compared to the control group, but not in self-efficacy or anxiety.

Jones and Landreth (2002) conducted a pretest posttest treatment control group study with children who were chronically ill. Thirty children, ages 7 to 11 years old, who were diagnosed with insulin-dependent diabetes were randomly assigned to either the treatment group that received 12 30-minute child-centered play therapy sessions or the control group. Pre- and posttreatment testing was conducted using the *Revised Children's Manifest Anxiety Scale*, *Filial Problem Checklist* (FPC), *Diabetes Adaptation Scale-Child Form*, and *Diabetes Adaptation Scale-Parent Form*. Results show children receiving CCPT had statistically significant increase in diabetes adaptation, although there were no statistical differences in ratings on anxiety or FPC.

Shen (2002) conducted a pretest posttest treatment control group study with Chinese children who were earthquake victims. Thirty students ages 8 to 12 years old who experienced symptoms after a Taiwan earthquake were randomly assigned to either the treatment group that received 10 40-minute group CCPT sessions or the control group. Pre- and posttreatment testing was conducted using the *Children's Mental Health Checklist*, *Filial Problem Checklist*, *Revised Children's Manifest Anxiety Scale* (RCMAS), and *Multiscore Depression Inventory for Children*. Results show children in the play therapy group had significant reductions in anxiety and suicide risk. Effect sizes showed there was a large treatment effect on anxiety and small to medium treatment effect on suicide risk.

Packman and Bratton (2003) conducted a pretest posttest treatment control group study with preadolescents who were learning disabled. Twenty-four fourth- and fifth-grade students with learning differences were randomly assigned to either the treatment group that received 12 one-hour group play/activity therapy or a control group. Pre- and post-treatment testing was conducted using the *Behavior Assessment System for Children-Parent Report Form* (BASC-PRF) and the *Child Behavior Checklist-Parent Report Form* (CBCL-PRF). Play therapy children had statistically significant improvement and large treatment effect on BASC overall composite scores and internalizing problems, but not on the CBCL.

Danger and Landreth (2005) conducted a pretest posttest treatment control group study with children with speech difficulties. Twenty-one children ages four to six years old who qualified for speech therapy were randomly assigned to either the treatment group receiving 25 30-minute group child-centered play therapy (CCPT) sessions in their school or the control group. Pre- and posttreatment testing was conducted using the *Goldman Fristoe Test of Articulation*, *Peabody Picture Vocabulary Test-Revised*, *Clinical Evaluation of Language Fundamentals Third Edition*, and *Burks' Behavior Rating Scale*. Results show group CCPT had large practical significance in improving expressive and receptive language skills and small practical significance in improving articulation and anxiety.

Garza and Bratton (2005) conducted a pretest posttest treatment comparison group study with Hispanic elementary school children. Twenty-nine Hispanic children who were referred for school counseling due to behavior problems were randomly assigned to either 15 30-minute weekly individual child-centered play therapy sessions or 15 30-minute weekly curriculum-based small group counseling. Pre- and posttreatment testing was conducted using the *Behavior Assessment System for Children (BASC)-Parent*

Rating Scale and *BASC-Teacher Rating Scale*. Results showed statistically significant decreases in externalizing behavior problems of children in the CCPT treatment group. The effect size revealed CCPT had a large treatment effect on externalizing behavior problems and a moderate treatment effect on internalizing behavior problems and on anxiety.

Ray (2007) conducted a pretest posttest treatment comparison study with elementary school children referred for school counseling. Ninety-three children ages 4 to 11 years old and 59 teachers were randomly assigned to (1) the play therapy group, (2) the teacher consultation group, or (3) the teacher consultation and play therapy group. Children receiving play therapy had 26 30-minute individual CCPT sessions. Teachers receiving consultation had eight 10-minute person-centered consultation sessions. Pre- and posttreatment testing was conducted using the *Index of Teaching Stress*. Results showed that all groups had statistically significant reduction in teacher and student problem characteristics with large effect sizes for total stress, Attention Deficit Hyperactivity Disorder (ADHD), and student characteristics. Play therapy had a significant impact on reducing teacher stress as affected by student characteristics and ADHD behaviors.

Ray, Schottelkorb, and Tsai (2007) conducted a pretest posttest treatment comparison study with children exhibiting symptoms of ADHD. Sixty elementary school children who exhibited attention problems and hyperactivity in the classrooms were randomly assigned to a play therapy group that received 16 30-minute individual CCPT sessions or a reading mentoring group that received 16 30-minute individual reading sessions. Pre- and posttreatment testing was conducted using the *Index of Teaching Stress* and the *Conners Teacher Rating Scale-Revised: Short form*. Results showed that both groups had statistically significant improvement on assessment ratings related to ADHD, anxiety/withdrawal, and learning disabilities. However, children receiving CCPT had statistically significant improvement on emotional lability and anxiety/withdrawal over children receiving reading mentoring.

The eight pre- and posttest experimental control or comparison group child-centered play therapy studies described above certainly meet the SCCAP criteria for Promising (''Probably Efficacious Treatments'') in that there are more than ''two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group.'' Even more, it appears that the two comparison studies conducted by Garza and Bratton (2005) and Ray et al. (2007) may meet the SCCAP criteria for Best Support (''Well-Established Treatments''), depending on how organizations interpret the standards. Another encouraging fact is that play therapy has been effective in natural real-world settings of schools, clinics, and shelters where children present with a variety of problems rather than just one specific diagnosis (Ray, 2006). This means that play therapy can be easily replicated by school counselors and community mental health practitioners who work with younger children from various diverse populations (Ray, 2006).

FILIAL THERAPY RESEARCH

Filial therapy has been defined as ''a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere'' (Landreth & Bratton, 2006, p. 11). Filial therapy can be implemented in a variety of timeframes such as Guerney's (2000) five- to six-month model or Landreth and Bratton's (2006) 10-week model. Filial therapy has also been adapted for implementation by teachers (Post, McAllister, Sheely, Hess, & Flowers, 2004) and peer mentors (Baggerly & Landreth, 2001). The following experimental and control or comparison group research studies demonstrated the effectiveness of filial therapy in decreasing parent's or teacher's stress and children's symptoms and improving the relationship with the child.

Glover and Landreth (2000) conducted a pre- and posttreatment control research study of filial therapy with Native American parents on the Flathead Reservation. Twenty-five parents or grandparents were assigned to either the experimental group that received Landreth's 10-week model of filial therapy or the control group based on convenience. Pre- and posttreatment testing was conducted using the *Porter Parental Acceptance Scale*, the *Parenting Stress Index*, the *Measurement of Empathy in Adult-Child Interaction*, the *Children's Play Behavior with Parent Rating Form*, and the *Joseph Preschool and Primary Self-Concept Screening Test*. Results indicate statistically significant increases for parents in the experimental group in empathic behavior and in experimental children's desirable play behavior (self-directiveness and connectedness with parents) compared to the control group.

Tew, Landreth, Joiner, and Solt (2002) conducted a pre- and posttreatment control research study of filial therapy with parents of chronically ill children. Twenty-three parents were assigned to either the treatment group that received Landreth's 10-week model of filial therapy or the control group. Pre- and posttreatment testing was conducted using the *Porter Parental Acceptance Scale*, the *Parenting Stress Index*, and the *Child Behavior Checklist-Parent Form*. Results showed that parents in the treatment group had significant increases in their attitude of acceptance toward their child and significant decreases in their parenting stress compared to the control group. In addition, children in the experimental group had significant decreases in behavior problems, anxiety, and depression, compared to the control group.

Jones, Rhine, and Bratton (2002) conducted a pre- and posttest treatment comparison research study of filial therapy with high school students who provided play sessions for prekindergarten and kindergarten children. Sixteen high school students were assigned to the treatment group that received 10 filial therapy training sessions 1.5 hours in length over 24 weeks and provided 20 20-minute play sessions with their assigned kindergarten child. Fifteen high school students were assigned to the comparison group that received traditional peer-mentoring training. Pre- and posttreatment testing was conducted using the *Child Behavior Checklist-Parent Form* and the *Measurement of Empathy in Adult-Child Interaction*. Results showed that high school students receiving the filial therapy had significant increases in their empathic interactions with children, compared to high school students in the comparison group. In addition, children who received play sessions had significantly fewer behavior problems than the control group.

Yeun, Landreth, and Baggerly (2002) conducted a pre- and posttest treatment control research study of filial therapy with immigrant Chinese families. Thirty-five parents were randomly assigned to either the treatment group that received Landreth's 10-week filial therapy training model or the control group. Pre- and posttreatment testing was conducted using the *Porter Parental Acceptance Scale*, the *Parenting Stress Index*, the *Filial Problem Checklist*, *Self-Perception Profile for Children*, and the *Perceived Competence and Social Acceptance for Young Children*. Results showed parents receiving filial therapy had significant increases in empathic interaction with their children and attitudes of acceptance of their children as well as significant decreases in parenting stress and children's behavior problems, compared to the control group. In addition, children of parents in the experimental group increased significantly in self-concept.

Smith and Landreth (2003) conducted a pre- and posttest treatment comparison research study of filial therapy with mothers and children who experienced domestic violence. Eleven mothers who were victims of domestic violence received 12 filial therapy sessions in a 2- to 3-week period. Eleven children in the experimental group received play sessions from their mothers training in filial therapy; 11 children in one comparison group received intensive individual play therapy from a trained play therapist; 10 children in another comparison group received intensive sibling group play therapy; and 11 children in the nontreatment comparison group received no intervention. Pre- and posttreatmet testing was conducted using the *Child Behavior Checklist-Parent Form*, the *Joseph Preschool and Primary Self-Concept Screening Test*, and the *Measurement of Empathy in Adult-Child Interaction*. Results showed that children who received filial therapy from their mother had significant decreases in behavior problems and significant increases in self-concept as compared to children in the nontreatment comparison group. In addition, mothers scored significantly higher on attitudes of acceptance and empathic behavior toward their children.

Lee and Landreth (2003) conducted a pre- and posttest treatment control group filial therapy research study with immigrant Korean parents in the United States. Thirty-six Korean parents were randomly assigned to either the treatment group that received Landreth's 10-week filial therapy training model or the control group. Pre- and posttreatment testing was conducted using the *Measurement of Empathy in Adult-Child Interaction*, *Porter Parental Acceptance Scale*, and the *Parenting Stress Index*. Results showed that parents in the experimental group significantly increased in their level of empathy and acceptance toward their children and significantly reduced their parenting stress, compared to the control group.

Post, McAllister, Sheely, Hess, and Flowers (2004) conducted a pre- and posttreatment experimental and control group research study on child-centered kinder training for teachers of preschool children deemed at risk. Nine preschool teachers who volunteered for the training were assigned to the experimental group that received filial therapy training, and eight additional teachers comprised the control group. Nine children who turned in their informed consent first were assigned to the experimental group that received play sessions from their teacher, and nine other children were assigned to the control group. Pre- and posttreatment testing was conducted using the *Behavior Assessment Scale for Children*, the *Assessment of Child-Centered Play Therapy Skills*, and the *Measurement of Empathy in Adult-Child Interaction*. Results showed statistically significant improvement in the behavior of children receiving play sessions from their teacher, compared to the control group. In addition, teachers in the experimental group had statistically significant improvement in play therapy skills and empathy, compared to the control group.

Smith and Landreth (2004) conducted a pre- and posttreatment experimental and control group research study on filial therapy with teachers of deaf and hard of hearing preschool children. Twenty-four teachers of deaf and hard of hearing preschool children were assigned to either the experimental group that received Landreth's 10-week model of filial therapy training or the control group. Twelve children were assigned to the experimental group that received 10 30-minute play sessions from their teachers, and 12 children were assigned to the control group. Pre- and posttreatment testing was conducted using the *Measurement of Empathy in Adult-Child Interaction*, the *Child Behavior Checklist-Teacher Form*, and the *Emotional Assessment of Deaf and Hard of Hearing Children*. Results showed that teachers in the experimental group had statistically significant improvement in acceptance and empathy toward their students in the play session compared to the control group. In addition, children receiving play sessions had statistically significant decreases in overall behavior problems compared to the control group.

The eight pre- and posttest treatment control group filial therapy studies described above also meet the SCCAP criteria for Promising (''Probably Efficacious Treatments'') in that there are more than ''two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group.'' Filial therapy comparison studies are needed to meet the criteria for a well-established treatment. Fortunately, at least one doctoral dissertation has accomplished this to date and is expected to be published in a journal soon (Morrison, 2007). A great advantage of filial therapy research is that a treatment manual was developed by Bratton, Landreth, Kellam, and Blackard (2006). This treatment manual will add to the likelihood that filial therapy will be recognized as a well-supported treatment in the near future.

COGNITIVE BEHAVIORAL PLAY THERAPY

Cognitive Behavioral Play Therapy (CBPT), as conceptualized by Knell (2003), incorporates cognitive, behavioral, and traditional play therapies. Knell advocates adapting cognitive principles of therapy for children ages 2 ½ to 6 years old by using ''puppets, stuffed animals, books, and other toys to model cognitive strategies'' (p. 178). Although Cognitive Behavioral Therapy has been well established with children (Cohen, et al., 2000), no CBPT research studies that met the above-mentioned criteria were found. However, there is one notable CBPT quasi-experimental research study that was published in a professional journal.

Hansen, Meissler, and Ovens (2000) conducted a pre- and posttreatment test using the *Child Behavior Checklist-Parent Form* on their Kids Together Program with 30 children ages 5 through 16 years old who had a diagnosis of Attention Deficit Hyperactivity Disorder. During nine two-hour sessions they used play therapy procedures (e.g., puppets, art, clay, storytelling) to teach children social skills (e.g., feelings identification, communication, conflict resolution, relaxation). Results showed significant decreases in internalizing behaviors and total behaviors, but not on externalizing behaviors.

PLAY THERAPY RESEARCH FUTURE DIRECTIONS

Over the past several years, play therapy research has become more sophisticated from the standpoint of meeting current EBP standards within the positivism paradigm. Some of the improvements within this millennium have been (1) reliable and valid assessment instruments that measure specific issues related to the presenting problem (e.g., CBCL, BASC, and TSCC); (2) comparison designs with other treatments (e.g., reading mentoring group); (3) clearer inclusion criteria for participants (e.g., meets diagnosis for ADHD); (4) use of treatment manuals; (5) follow-up and longitudinal research, and (6) appropriate data analysis (e.g., effect size) (Ray, 2006). These trends need to continue and replication of studies by different researchers needs to be conducted in order for play therapy and filial therapy to meet EBP criteria.

In addition, since a large number of single-case design experiments will also fulfill the ''Best Support'' criteria, play therapy researchers should design case studies with baseline assessment of at least three weeks and continuous assessment over different treatment phases of play therapy (Kennedy, 2005; Morgan & Morgan, 2003). For example, Schottelkorb (2007) conducted a single-case design measuring the effectiveness of CCPT on ADHD behavior problems of elementary school children. Another example of a single-case design related to play is provided by Ridgway, Northup, Pellegrin, LaRue, and Hightsoe (2003).

Within the realism paradigm, play therapy researchers should look for the active ingredients within well-established play therapy treatments. For example, researchers could conduct well-designed comparison studies to determine if significant differences in children's assessment scores are due to inclusion of particular toys (e.g., sandtrays, Bop Bags, dollhouses, puppets) or specific therapeutic procedures (e.g., allowing the child to lead, enlarging the meaning, psychoeducation, parent consultation). Within the postmodern paradigm, play therapy researchers should conduct qualitative studies, especially regarding cultural and linguistic applications.

Future research should also explore the integration of play therapy and CBT. In Cohen, Mannarino and Rogal's (2001) survey of 247 therapists and psychiatrists, many respondents stated they use nondirective play therapy despite limited research to substantiate that it is superior. These researchers stated experienced therapists may detect important therapeutic benefits and changes that have not been measured by research trials. Therefore, one of the most important future research directions is to measure the impact of integrating play therapy with CBT protocol. For example, researchers could compare standard Trauma Focused-CBT with Trauma Focused-CBT that incorporates play therapy techniques.

CONCLUSION

Play therapy research must be considered within historical and philosophical context. Play therapy research began with case studies by A. Freud, Klein, and Axline and has progressed to more complex quantitative and qualitative research designs. Although play therapy research is at an earlier developmental stage compared to child psychology, play therapy appears to have a similar research trajectory as child psychology. The three different philosophical approaches of positivism, realism, and postmodernism evaluate the effectiveness of play therapy through different research standards. Yet, many researchers believe the collective wisdom of all research methods provide empirical support.

When comparing play therapy research to the current EBP criteria within the positivism perspective, both play therapy and filial therapy meet standards for Promising (i.e., Probably Efficacious) Treatments. There is a bright and encouraging outlook for play therapy to meet criteria for Best Support (i.e., well-established treatments) in the near future. New play therapy research studies should focus on random assignment of participants in treatment comparison designs with either well-established treatments or integration of CBT into play therapy. Additional research studies are needed within the realism paradigm to identify the active ingredients of play therapy. Qualitative studies within the postmodern paradigm are also needed to create in-depth understanding, especially in cultural and linguistic application of play therapy. In conclusion, play therapy should be considered an effective treatment with a rich history of research and a bright future.

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CHAPTER 6

Cognitive Behavioral Play Therapy

Theory and Applications

SUSAN M. KNELL

INTRODUCTION

Cognitive Behavioral Play Therapy (CBPT) is a developmentally appropriate treatment, designed specifically for young children (3–8 years old). Through CBPT, children are helped to be active participants in change and gain mastery over problems. It is based on cognitive and behavioral theories of emotional development and psychopathology, and on interventions derived from these theories. CBPT is an offspring of Cognitive Therapy (CT) as conceptualized by Aaron Beck (1964, 1976).

CT contends that behavior is mediated through verbal processes; the way individuals construe the world in large measure determines how they behave and feel and how they understand life situations (Beck, 1967; 1972; 1976). Beck noted that an individual's emotional experiences are determined by cognitions that have developed, in part, from earlier life experiences. Over the past 50 years, CT has been applied to increasingly broad populations. CT as practiced with adults is inappropriate for use with adolescents and children without modification, as a more developmentally appropriate approach is necessary. Over time, adaptations of CT for use with increasingly younger populations have emerged (e.g., adolescent—1983; school-age children—1985). However, many believed that CT could not be adapted for preschool and very young school-age children.

Clinical lore suggests that therapy with preschoolers must involve some level of play therapy in order to engage the child in what is traditionally a more verbal endeavor. Historically, the developmental literature noted that preoperational stage children do not have the cognitive sophistication and flexibility to benefit from CT. CT emphasized the effects of maladaptive or dysfunctional beliefs and attitudes on behavior and how one's reaction to events are influenced by the meaning that the individual attaches to such events. Given that CT with adults requires the ability to follow a rational, logical sequence, such cognitive sophistication is typically not present in young children. Further, for CT to be effective, individuals must have the capacity to differentiate between rational and irrational/logical and illogical thinking. An adult may need some guidance in identifying and labeling irrational, illogical thoughts. However, once identified, most adults can understand the inconsistencies.

Young children, however, may not understand the differences and may not be able to distinguish between irrational, illogical thinking and more rational, logical thought. The application of CT with young children is thus fraught with difficulties, which largely explains why most of the work with youth and CT has focused on adolescents and older school-age children. At the preoperational stage, a child's egocentrism, concrete thought processes, and seemingly irrational thinking would seem to preclude the kind of cognitive abilities necessary to participate in CT.

ADAPTING CT FOR USE WITH CHILDREN

CT was developed as a structured, focused approach to help individuals make changes in their behavior by changing the thinking and perceptions that underlies behavior. Originally developed as a short-term, present-oriented therapy for depressed adults, the treatment was directed toward changing dysfunctional thinking and behavior. Adaptations to younger populations have changed the methods through which CT is delivered, but not the theoretical underpinnings of the approach. Finding ways to deliver CT without an emphasis on language that might be too complex for a young child represents one of the challenges faced in the development of CBPT.

Knell (1993a, 1993b, 1994, 1997, 1998) argued that CT could be modified for use with young children if presented in a way that was highly accessible for children. For example, puppets, stuffed animals, books, and other toys could be used to model cognitive strategies. Researchers, such as Bandura (1969) and Meichenbaum (1971) found that coping models are more effective than mastery models in facilitating changes in behavior. Coping models make "mistakes" along the way and model learning from these mistakes. The child is then observing a model in its efforts to learn more appropriate behaviors. With a coping model approach, the model (e.g., puppet) might verbalize problem-solving skills or solutions to problems that parallel the child's own difficulties.

CT, with its emphasis on verbal interventions, and play therapy (PT), with its focus on play, appeared to many as incompatible. Nonetheless, by the mid-1980s, Phillips (1985), himself a developmentalist, not a clinician, hypothesized that incorporating cognitive behavioral techniques into play interventions offered a promising direction in the field of PT. At the same time, others, such as Berg (1982, 1989), had begun to incorporate CT and play interventions, although Berg's target population was slightly older, school-aged children. In 1990, when Knell and Moore published a case report on the use of Cognitive Behavioral Play Therapy (CBPT) with an encopretic 5-year-old, it represented the first published case report of the integration of cognitive interventions and play therapy with a preschool-age child.

Adapting CT for preschoolers has received increasing attention over the last 10 years. CBPT, as conceptualized by Knell (1993a, 1993b, 1994, 1997, 1998, 1999, 2000; Knell & Moore, 1990; Knell & Ruma, 1996, 2003; Knell & Beck, 2000, Knell & Dasari, 2006) was developed for use with children between 2½ and 6 years old and incorporates cognitive, behavioral, and traditional play therapies. CBPT is based on the cognitive theory of emotional disorders and cognitive principles of therapy, and it adapts these in a developmentally appropriate way. It is sensitive to the developmental issues of children and emphasizes the empirical validation of effectiveness of interventions.

Cognitive distortions in very young children may be developmentally appropriate, yet maladaptive. For example, a child whose parents separate shortly after he misbehaves may believe that he was the cause of the separation. In most cases, children incorporate life experience into their thinking and, with the help of everyday parent-child discourse, are able to integrate this learning into a more adaptive thought (''My parents weren't getting along. Dad didn't move out because of my behavior. He moved out because he and mom fight too much.''). Given that maladaptive thoughts may be developmentally appropriate, the concept of cognitive distortions is problematic with young children. For this reason, it is more appropriate to label these thoughts maladaptive, rather than distorted.

Sometimes, children do not attach any set of beliefs or meanings to an event. In these instances maladaptive cognitions may not be present. However, there may be an absence of adaptive beliefs that would facilitate coping. In these instances, the child might need some assistance in creating functional, adaptive self statements as a coping device, not to replace the maladaptive ones, but to boost more adaptive thinking and behavior. For example, a young child may have difficulty coping with the birth of a sibling. Maladaptive beliefs (e.g., ''I'm not the baby anymore,'' ''No one loves me'') may not be present, or they may not be expressed verbally. Helping the child cope with the new sibling by providing adaptive, positive coping statements can facilitate the child's functioning. Statements such as ''We have a new baby, but mom and dad still love me'' can provide the child with a positive outlook on the experience. Such statements can replace maladaptive beliefs (either spoken or felt, but not verbalized) or be a new cognition replacing either neutral or nonexistent beliefs.

Thus, facilitating adaptive cognitive change is not only possible, but also quite common with young children. Often, as mentioned, inducing such change takes place in the normal, everyday life of parent-child interactions. When situations are brought to a therapist, the use of developmentally appropriate adaptations of CT to facilitate such changes may be indicated. Bierman (1983) wrote about interviewing techniques, including the use of concrete examples and less open-ended questions, as a means to facilitate the young child's understanding of complex problems. Through the use of play, cognitive change can be communicated indirectly (Shirk & Russell, 1996; Knell, 1998). Additionally, the therapist's ability to be flexible, reduce focus on verbalizations, and increase use of experiential approaches can contribute to the successful adaptation of CT with young children (Knell & Ruma, 1996, 2003; Knell & Dasari, 2006).

CBPT has been used with children presenting with a wide range of diagnoses, such as selective mutism (Knell, 1993a, 1993b), anxiety and phobias (Knell, 1993a, Knell & Dasari, 2006), encopresis (Knell & Moore, 1990; Knell, 1993a), and those who have experienced traumatic life events, such as sexual abuse (Knell & Ruma, 1996, 2003).

TREATMENT DESCRIPTION

TREATMENT STAGES

CBPT takes place as the child moves through several treatment stages, which have been described as the introductory/orientation, assessment, middle, and termination stages.

Introductory/Orientation. Often the child is introduced to the notion of play therapy by the parents after they have met with the CBP therapist. During that initial interview, one of the therapist's tasks is to help the parent(s) understand how best to prepare the child for his/her first session. The therapist should spend some time discussing the most developmentally appropriate explanation for the child. Books, such as *A Child's First Book About Play Therapy* (Nemiroff & Annunziato, 1990), can be recommended to the parent as a helpful adjunct to their discussion with the child.

Assessment. After preparation for CBPT, the assessment begins. Presenting problems are better understood, diagnostic clarity is reached, and a treatment plan is developed during the early stages of CBPT. In addition to a parent interview and child observation, assessment may include parent report inventories (e.g., Child Behavior Checklist, Achenbach, 1991), play assessment, The Puppet Sentence Completion task (Knell, 1992; Knell, 1993a; Knell & Beck, 2000), or therapist-created measures.

Middle Stage. During the middle stage of CBPT, the therapist has developed a treatment plan, and the therapy is turning to focus on increasing the child's self-control, sense of accomplishment, and learning more adaptive responses to deal with specific situations. Depending on the presenting problem(s), the therapist will have a wide array of cognitive and behavioral interventions from which to choose. These are considered carefully, with as much specificity as possible related to the intervention and the child's specific problems/concerns. The focus in the middle of therapy is on increasing the child's self-control, sense of accomplishment, and developing more adaptive responses to deal with specific situations. Much of the actual therapy and the use of cognitive behavioral interventions take place during this middle stage. Generalization and relapse prevention will be incorporated into the middle stages of therapy so that the child can learn to utilize new skills across a broad range of settings and begin to develop skills that will limit the chances of setbacks after therapy is completed.

Termination Stage. During the termination phase, the child and family are prepared for the end of therapy. As the treatment nears an end, the child deals with the reality of termination, as well as feelings about ending treatment.

For more complete descriptions of these stages in CBPT, see Knell (1999).

METHODS AND INTERVENTIONS

Most cognitive behavioral interventions with children of all ages include some form of modeling. This is particularly true of CBPT, where modeling is a critical component in the play. In CBPT, modeling is used to demonstrate adaptive coping skills to the child, with a toy demonstrating the behavior that the therapist wants the child to learn. Modeling can also be presented in other forms, such as through books, movies, or television shows.

Another method of delivering CBPT is through role-playing, where the child practices skills with the therapist. This method is often more effective with school-age children, although role-playing in itself can be delivered through modeling. For example, the models can be role-playing, and the child is observing and learning from watching the models.

CBPT interventions can be categorized as either behavioral or cognitive. Behavior therapies (BT) for youth were developed, in part, to help children and parents translate knowledge gained in therapy to the natural environment. Often, behavioral approaches to child management are taught directly to parents or significant others. Such approaches have proven extremely effective with problems such as child noncompliance. However, BT can be implemented directly with a child, and a direct approach may be indicated for certain problems. This may be particularly true if the child's problem is aversive to the parent (e.g., Knell & Moore, 1990), if the parent-child relationship has inhibited development of the child's self mastery (Klonoff, Knell, & Janata, 1984; Klonoff & Moore, 1986), or if issues of control are prominent. Whether the therapy is direct or delivered through a significant other, the therapist tries to identify factors that reinforce and maintain problematic behaviors so that they can be altered. Many interventions are based on classical conditioning (e.g., systematic desensitization) and operant conditioning (e.g., contingency management). Interventions from social learning theory also emphasized observational learning and more cognitive aspects of behavior, which provided much of the impetus for the development of cognitive therapy.

Behavioral methods usually involve an alteration in activity, whereas cognitive methods deal with changes in thinking. Because maladaptive thoughts lead to maladaptive behavior, changes in thinking should produce changes in behavior. Through cognitive interventions, children learn to identify maladaptive thoughts, replace them with more adaptive ones, and ultimately change maladaptive behaviors. Because of the verbal nature of cognitive interventions, CBPT relies on modeling, and more developmental adaptations, in order to deliver these interventions in more child-friendly ways.

DEVELOPMENTAL ISSUES

Young children present some unique challenges in psychotherapy. Given cognitive limitations, including the concrete and egocentric nature of children's thinking at this age, the more verbal nature of psychotherapy can be difficult. For most young children, distinguishing between illogical, irrational thoughts and more logical, rational ones is problematic. Despite these challenges, Knell and her colleagues have demonstrated that cognitive behavioral therapy can be communicated to children through play (e.g., Knell, 1993a, 1994, 1997, 1998, 1999; Knell & Moore, 1990; Knell & Ruma, 1996, 2003; Knell & Dasari, 2006).

Because cognitive behavioral approaches often rely on fairly sophisticated cognitive abilities (e.g., abstract thinking, hypothesis testing) and collaborative empiricism, questioning its use with young children makes sense. However, there is ample evidence to suggest that young children's ability to understand complex problems may be enhanced by specific techniques. Clinicians and researchers alike have noted that children's ability to understand complex problems can be improved by specific approaches (e.g., Bierman (1983) recommended using concrete examples and fewer open-ended questions to facilitate children's understanding). Rather than assuming that children cannot benefit, it makes sense to consider ways to make interventions more developmentally appropriate, and accessible to this young population.

In order to be more appropriate, the complexity of a given intervention needs to be matched with the developmental level of the child. The CBPT therapist should capitalize on the child's strength and abilities, rather than focusing on weaknesses. More experiential interventions incorporating play, rather than complex cognitive and verbal skills are likely to be most useful.

One important area for intervention is encouraging and facilitating language to describe experiences and emotions. Despite dramatic growth in vocabulary during these early preschool years, the child's descriptive vocabulary for emotions is still often quite limited. In addition to words to describe feelings, young children often benefit from help in matching their behaviors and feelings, and learning to express feelings in more adaptive, language-based ways. For example, rather than expressing frustration and anger through aggression, a child can be taught to understand that he is angry and express that feeling in words rather than behavior. In doing so, the child may benefit from a sense of control and mastery, and certainly more positive feedback from the adults around him! For children, play is a developmentally appropriate and a natural means of communication. The child can use the toys as their words and the play as their communication/language that the CBPT can help articulate for them.

STRUCTURED VERSUS UNSTRUCTURED PLAY

For CBPT to be effective, it should provide structured, goal-directed activities, as well as unstructured time during which the child brings spontaneous material to the session. The balance of spontaneously generated and more structured activities is a delicate one in CBPT. Unstructured, spontaneously generated information is critical to the treatment, for without it the therapist would lose a rich source of clinical information. On the other hand, when therapy is completely unstructured and nondirective, it is not possible to teach more adaptive behaviors such as problem solving.

GOALS

Establishing goals is an important part of CBPT. The CBP therapist works with the child and family to set goals and help the child work toward these goals. The therapist assesses movement toward goals on an ongoing basis. Whereas goals and movement toward goals are counter to the basic philosophy of more traditional play therapies, such as client-centered play therapy (see Axline, 1947), they are an integral part of CBPT. The CBP therapist's selection of a direction may still be child-led, based on the child's lead or on knowledge of the child's situation as understood from the parent interview or other source. In CBPT, the therapist may introduce themes and provide direction based on knowledge obtained from a parent or teacher and not necessarily directly from the child. For example, the CBP therapist may purposefully and systematically have a puppet behave in a certain way and verbalize issues that the child reportedly exhibits.

PRINCIPLES OF CBPT

Knell (1993a, 1994) delineated the principles of CBPT, as adapted from principles for CBT (referred to in their writing as CT) with adults (Beck & Emery, 1985). The following principles (numbers retain the original principle number as delineated by Beck & Emery) apply to work with young children in CBPT.

1. **CT is based on the cognitive model of emotional disorders.** This model, based on the interplay of cognition, emotions, behavior, and physiology, suggests that behavior is mediated through verbal processes. Maladaptive or disturbed behavior is considered to be an expression of irrational thinking. CT with adults is focused on changing cognitions, altering irrational, maladaptive or illogical

thinking. This model is applicable for children, however developmental considerations are critical. The thinking of a child in the preoperational stage of thought is often irrational in nature. Behavior and activity may precede thought because of immaturity or impulsivity. Thinking is not necessarily adaptive, particularly as the child does not have an accumulated history with which to carefully consider alternatives. Thus, CT with young children may focus on the absence of adaptive thoughts (deficits), rather than on cognitive distortions per se.

2. **CT is brief and time limited.** In 1985 when Beck and Emery referred to CT as brief, they were speaking of a treatment that typically lasted less than six months. Their rationale was that CT encouraged the individual's self-sufficiency and discouraged dependence on the therapist. Its nature was to be task oriented and problem-solving oriented. Times have changed, and brief likely means even fewer than six months of treatment. Nonetheless, keeping treatment brief and time limited is often the treatment of choice for children. This allows the treatment to be focused on immediate relief of difficulties, providing problem-solving strategies and coping skills, and quickly returning a child to a prior optimal developmental level of functioning.
3. **A sound therapeutic relationship is a necessary condition for effective CT.** As in all forms of psychotherapy, CT relies on establishing a warm, therapeutic relationship based on trust and acceptance. A positive therapeutic relationship is the best predictor of treatment outcome (Brady et al., 1980), with play therapy being no exception. If therapy is to be seen as a safe, accepting place where communicating about oneself is permissible, the therapist will need to be seen as a trustworthy, nonjudgmental confidant.
6. **CT is structured and directive.** CT provides a structured, directive format, which allows agenda setting and focusing on specific goals. With children, such structure is always balanced with more unstructured, spontaneous play. Often it is during this unstructured, child-led play that issues arise that the child might not raise during more structured times. This balance is delicate, but the importance of structured and directive activities in CBPT is critical to its success.
7. **CT is problem oriented.** With adults, CT is focused on identifying specific problems and implementing interventions to alleviate these problems. Such focus is also critical in CBPT, where children are often brought to treatment with specific problems for which their parents are seeking help. Critical, however, is clarifying the problems versus

the symptoms, as often children's presenting problems are more symptom rather than problem focused. For example, a child who is soiling his pants and physically aggressive after being abused is exhibiting symptoms of the presenting problem (sequelae of the abuse). Such a child might have issues of trust and control after the abuse, with the symptoms (e.g., soiling, hitting) being the physical manifestations of these problems.

8. **CT is based on an educational model.** The CT model contends that symptoms develop because an individual has learned inappropriate ways of dealing with situations. The CT therapist is a teacher in the sense that they impart positive coping skills and alternatives to the current maladaptive ways. With young children, teaching alternatives can be critical, because such self-generating of more positive coping skills is often beyond the child's reach without modeling and guidance.

Several principles apply, with modification, to young children:

4. **Therapy is a collaborative effort between therapist and patient.** With adults, a team approach is a critical part of the therapeutic relationship. Though important with children, collaboration may be very different, with the therapist finding a balance between imposing direction on the child and accepting the child as he/she is. Further, some of the collaboration will take place between therapist and parent, rather than directly with the child. This collaboration may supplement the work between child and therapist, particularly as it relates to the child's environment and home situation.
5. **CT primarily uses the Socratic method.** CT uses the question as a lead and avoids direct suggestions and explanations. Through the use of questions, the individual is helped to alter maladaptive thinking. Questions such as "What is the evidence? What can you learn from this?" eventually are incorporated into the patient's repertoire to counter irrational thoughts and develop more adaptive, rational thinking. Such questions are typically not effective with children, though the use of open-ended questions can be helpful. For example, "I wonder how that feels to you" is more likely to get a response from a child than a question like, "What do you think about that?" The former statement/question is Socratic in nature, although different from what one traditionally considers a Socratic question with an adult.
9. **The theory and techniques of CT rely on the inductive method.** Adults are taught a scientific approach to problems, with beliefs viewed as hypotheses to be revised based on new data. Conducting

experiments to test these beliefs is part of the work adults do in CT. Since such hypothesis testing is typically not possible for the young child, some of this work is done for rather than with the child.

10. **Homework as a central feature of CT does not apply to CBPT with young children.** With adults, generalization outside of therapy is promoted through between-session assignments, which reinforce and supplement work done in therapy. However, such assignments are rarely used with children, and almost never used with preschool-age individuals.

GENERALIZATION AND RELAPSE PREVENTION

It is important for children to generalize more adaptive behaviors to the natural environment and to maintain these behaviors after treatment has ended. Ideally, therapy should include work promoting generalization (Meichenbaum, 1977). Generalization can be dealt with through using real-life situations in modeling and role-playing, teaching self-management skills, involving significant adults and caregivers in the treatment, and continuing with treatment past the initial acquisition of skills to ensure that adequate learning takes place.

Therapy should also be geared toward helping the child and family prevent relapse. High-risk situations should be identified, and the child and parents should be prepared for handling such potentially disruptive situations. In this way, the child is inoculated against failure (Meichenbaum, 1985; Marlatt & Gordon, 1985). High-risk situations may coincide with normal developmental tasks (e.g., starting a new school year) or with the child's life situation (e.g., coping with a divorce). In CBPT, the therapist may create play scenarios similar to what the child might be facing in the future, and include adaptive coping skills and positive behaviors as part of the play. Generalization and relapse prevention are incorporated into the middle stages of therapy so that the child can learn to utilize new skills across a broad range of settings and to begin to develop skills that will decrease the chances of setbacks after therapy is completed.

CBPT VERSUS TRADITIONAL PLAY THERAPIES

SIMILARITIES/DIFFERENCES

Historically, play therapy has been based on either psychodynamic or client-centered theories. CBPT is different from these more traditional forms of play therapies, although it incorporates several of the assumptions

Table 6.1
Similarities: CBPT vs. Traditional Play Therapies

Therapeutic Relationship
Establish contact with child
Engage child in treatment
Engender child's trust
Play as Communication
Play is treatment modality as well as means of communication
Therapy as safe place
Provide child with sense of security and safety

underlying them. CBPT is similar to other types of play therapy in its reliance on a positive therapeutic relationship, use of play as a means of communication between therapist and child, and the message to the child that therapy is a safe place. Despite these similarities, there are assumptions inherent in CBPT that run counter to the premises on which traditional play therapies are based. Several important areas of difference involve the focus in CBPT on directions and goals, choice of play materials and activities, play as educational, and the importance of making connections between the child's behavior and thoughts. Whereas the therapist in nondirective play therapy is a more neutral observer, the CBP therapist provides direction, establishes goals, and develops interventions that are suited to facilitate these goals. Similarly, the CBP therapist, along with the child, selects play materials and activities, and provides a psychoeducational component to the treatment. Finally, the CBPT brings conflicts and problems into verbal expression for the child, using the therapeutic time and relationship to help the child make connections between words and behavior. (See Knell, 1993a, for more details regarding the similarities and differences among various types of play therapies.)

These similarities and differences are summarized in Table 6.1 and Table 6.2.

EMPIRICAL SUPPORT

CBPT is a developmentally based, integrated model of psychotherapy, and is solidly grounded in data-based psychological interventions (APA task force on the promotion and dissemination of psychological procedures, Chambless et al., 1996). It incorporates empirically supported techniques,

Table 6.2

Differences: CBPT vs. Traditional Play Therapies

	Psychodynamic	Nondirective (Axline, 1947)	CBPT
Direction and Goals	Direction does not come from therapist	Direction is not accepted because it imposes on child, suggests child is not accepted as he/she is	Therapeutic goals are established; direction toward goals is basis of intervention
Play Materials and Activities	Therapist is participant observer; therapist does not suggest materials or activities	Play materials/activities, direction of play always selected by child	Both child and therapist select materials and activities
Play as Education	Play is not used to educate; education is not goal of therapy	Education is not appropriate because it is a form of direction	Play is used to teach skills and more adaptive behaviors
Interpretations/ Connections	Interpretation is ultimate goal	Connections not made by therapist unless child introduces them first, therapist communicates unconditional acceptance, not interpretation of symbolic play	Connections introduced by therapist, who brings conflicts into verbal expression for child
Praise	Praise is not considered appropriate	Praise should not be used by therapist	Praise is crucial component, communicates appropriate behaviors and reinforces child

such as modeling. Research suggests that learning through modeling is an effective way to acquire, strengthen, or weaken behaviors, and thus it is an efficient and effective way to acquire behaviors and skills (Bandura, 1977). Other well-documented interventions, such as systematic desensitization, are utilized in CBPT (Wolpe, 1958, 1982).

CT with adults is a well-established, empirically supported treatment with a range of presenting diagnoses (e.g., anxiety, depression). Controlled studies have demonstrated its efficacy in the treatment of major depression (see Dobson, 1989, for a meta-analysis), generalized anxiety disorder (Barlow, Craske, Cerney, & Klosko, 1989; Beck, Sokol, Clark, Berchick, & Wright, 1992; Clark, Salkovskis, Hackmann, Middleton, & Gelder, 1992), and social phobia (Gelernter et al., 1991; Heimberg et al., 1990), to name a few. The foundations of CBPT are based on adapting empirically supported techniques for use with younger children using developmentally appropriate play. However, the efficacy of adaptations of CT for young children has not yet been demonstrated. Although CT with adults has been empirically validated, this does not necessarily mean that such treatment is most effective with children. Only recently has the question of the efficacy of CBPT been subjected to empirical study.

In a recent study, Pearson (2007) found that teachers reported significantly higher hope, higher social competence, and fewer anxiety-withdrawal symptoms in a cognitive behavioral play intervention group than a matched control group of preschool children without play. The children in the CB play intervention group were seen individually for three sessions incorporating CB interventions, though this was not technically CBPT. However, this study represents the first to empirically support CBPT interventions. More such studies will be needed on the road toward establishing the efficacy of CBPT.

SUMMARY AND CONCLUSIONS

CBPT is designed specifically for young children. It emphasizes the child's involvement in therapy and addresses issues of control, mastery, and responsibility for changing one's own behavior. The child is helped to become an active participant in change (Knell, 1993a). By presenting developmentally appropriate interventions, the therapist helps the child benefit from a type of therapy that might otherwise be inaccessible. A wide array of cognitive and behavioral interventions can be incorporated into play therapy, and its use with a wide range of presenting problems is emerging. CBPT provides structured, goal-directed activities, while allowing the child to bring spontaneous material to the session. The balance of spontaneously generated and more structured activities is a delicate one, though both are critical to the success of CBPT. Without the spontaneous material, a rich source of clinical information would be lost. Similarly, if the structure and direction of CBPT were not present, it would be impossible to help the child develop more adaptive coping skills. There is reason to believe that children who need to learn more adaptive coping skills, or whose involvement directly in treatment is important, would be ideal candidates for CBPT. Determining which young children are best treated indirectly through their parents and which are better candidates for direct treatment through CBPT is an important question.

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SECTION III

EFFECTIVE EVIDENCE-BASED TREATMENTS USING PLAY WITH CBT

SECTION III CONTAINS five chapters that are considered to be evidence-based treatments for children that incorporate play and play-based approaches. Each chapter author offers their rationale for including play within their EBT approach. Case studies help the reader to better understand how to apply and utilize play and play-based interventions within the presented approach. The first three chapters in this section offer cognitive behavioral approaches that have incorporated play for dealing with family treatment, anxiety disorders, and aggressive children. The remaining two chapters focus on child-led approaches that utilize the parent or paraprofessional.

The first chapter in this section by Susan Hansen and Glenn Saxe looks at Trauma Systems Therapy. This approach works to assess and intervene in the lives of families and children who have suffered traumatic experiences that resulted in functional impairment in the ability to self-regulate emotions and behavior. A Family and Child Unit in the mid-Hudson region of New York is highlighted in its successful use of TST with the incorporation of play and play-based interventions with children and families with severe emotional and behavioral dysregulation, where other treatment approaches had been unsuccessful. Case examples and vignettes help the reader to better understand the therapeutic powers of play and its incorporation into a cognitive behavioral play therapy approach for traumatized children which was effective. The TST model is broken down into its various modules that give the reader a clear picture of treatment areas addressed and techniques that can be applied. The authors conclude that play provides an avenue for processing material in the service of ego development leading to skill acquisition. And they support the belief that, within Trauma Systems Therapy, play therapy combined with sequenced cognitive behavioral skill building therapy is an effective treatment strategy for traumatized children.

Chapter 8 focuses on the incorporation of play within a manual-based treatment for children and adolescents with anxiety disorders. Authors Jennifer Podell, Erin Martin, and Philip Kendall highlight the need for play-related activities as a feature of treatment given the unwillingness of children and adolescents to sit and talk about their issues due to impulsivity, limited self-reflection, and nondisclosure. Such behavior makes use of treatments that rely on verbal exchanges, learning, working collaborations, and sharing of emotional experiences unsuccessful. They see play as part of a ''larger conceptualization of psychological intervention'' that makes the treatment effective. This chapter focuses on the ''Coping Cat'' program which provides the therapist with a manual and child workbook for 16 sessions of treatment. The approach is a synthesis of behavioral and cognitive strategies, along with social and emotional aspects included. The inclusion of play and fun activities provide an age-appropriate method of treatment delivery. Through a step-by-step description, the reader is able to see how the treatment program evolves and purpose of the play-based activities. The inclusion of play-based activities facilitates engagement and child involvement, which is an important predictor of treatment outcome. In addition, play activities allow for remembrance and incorporation of tools into their coping repertoire, along with the maintenance of therapy-produced gains. The authors advocate for a flexible approach to manual-based treatment incorporating play activities, notably for anxiety disorders in children and adolescents.

Chapter 9 looks at the role of play within CBT for aggressive children. Authors John Lochman, Caroline Boxmeyer, and Nicole Powell highlight the Coping Power Program, which is an empirically supported CBT intervention for late elementary and early middle school-aged children presenting with behavioral problems. This program incorporates several different structured play techniques, which utilize puppets, question-and-answers, beat-the-clock activities, and role-plays.

Play activities are incorporated to help with engagement, maintenance of interest, repetition in mastering new concepts and skills, and to accommodate different learning styles. Several examples are included so the reader can better understand how this treatment model is presented. A parent-child component is incorporated, with heavy emphasis placed on the importance of having time spent together and having fun. The authors conclude the chapter, based on their success with the Coping Power Program, with a clear statement that ''play therapy techniques are sometimes presented as being antithetical to cognitive behavioral therapy approaches with children and their families, but it is apparent that play can clearly be used in the service of evidence-based cognitive behavioral therapies.''

Anthony Urquiza, Nancy Zebell, and Dawn Blacker present in Chapter 10 how the evidence-based treatment of Parent-Child Interaction Therapy can be and is integrated with play therapy. The authors offer an overview of the history and foundations of PCIT and describe its protocol, along with the research evidence highlighting its efficacy and effectiveness in addressing and reducing child behavior problems. The authors go on to highlight how the originator of PCIT, Sheila Eyberg, recently acknowledged that early conceptual influences in her development of PCIT came from two early pioneers in play therapy: Virginia Axline and Bernard Guerney.

Along with two other formative mentors, Eyberg developed a behavioral intervention that improved parenting skills, decreased child behavioral problems, and indirectly strengthened parent-child attachment. The authors outline PCIT, a treatment intervention for children between the ages of 2 and 8 with some type of externalizing disorders, and offer clear examples of each phase and what occurs. Chapter 10 also addresses whether parenting training is play therapy. Traditional play therapists might not consider PCIT play therapy. However, the authors advocate that the essential elements of Landreth's definition of play therapy are met by the relationship between child and therapist, focus on development of appropriate and safe expression/communication, and the use of the medium of play as a central theme. They then offer many verbatim transcripts of session phases that meet these criteria and conclude that it is indeed a form of play therapy as well as an effective and well-researched intervention.

This section closes out with Chapter 11, which highlights the Primary Project, a treatment program for school adjustment that has received evidence-based status. Stephen Demanchick, Mary Anne Peabody, and Deborah Johnson review 50 years of the treatment program's research and success. The Primary Project is a school-based early detection and prevention program, which enhances social, emotional, behavioral, and learning skills, as well as reduces social, emotional, and school adjustment difficulties of children from preschool through third grade.

Developmentally appropriate child-led play by trained paraprofessionals is utilized to address at-risk children's issues. Research has shown that the Primary Project helps children become more productive in school. The authors clarify that this program is not considered therapy or specifically play therapy due to the use of paraprofessionals and that the program targets children with mild school adjustment difficulties. However, they do specify that it is a play-based approach and that its theoretical principles derive from child-centered play therapy literature and conceptualize the intervention. The reader is able to obtain from the authors a full description of the curative factors of play, the design of the playroom and materials used, as well as the implementation of the program.

CHAPTER 7

Trauma Systems Therapy: A Replication of the Model, Integrating Cognitive Behavioral Play Therapy into Child and Family Treatment

SUSAN HANSEN
GLENN SAXE

THIS CHAPTER WILL provide an overview of an outpatient mental health clinic's replication of the Trauma Systems Therapy (TST) model. TST works to assess and intervene in the lives of families and children who have suffered traumatic experiences that have resulted in functional impairment in emotional and behavioral self-regulation capacities. Interventions focus not only on the individual child, but also on the social environment (family and/or system of care) that surrounds the child. The rationale for the use of TST within a particular New York state county, as well as the social context and physiology of trauma, will be discussed along with how play and cognitive behavioral therapy have been integrated into the larger framework of the model.

NATIONAL SOCIAL CONTEXT

The number of children reported to authorities for abuse and neglect has recently been on the rise. In 2001, there were approximately 3 million children reported to appropriate authorities (Child Maltreatment, 2001). In

2004, ''an estimated 3,503,000 children received an investigation by CPS agencies'' (Child Maltreatment, 2004, p. 23). In 2005, the number of children who received an investigation by CPS agencies was 3.6 million (Child Maltreatment, 2005). These numbers fail to indicate the full extent of the problem of child abuse and neglect since we know many incidents are never reported. According to Bruce Perry, researcher and clinician in the field of child trauma, ''In one large survey, about one in eight children under the age of seventeen reported some form of serious maltreatment by adults within the past year. . . . In a national survey conducted in 1995, 6 percent of mothers and 3 percent of fathers . . . admitted to physically abusing their children at least once'' (Perry & Szalavitz, 2006, p. 3). Possibly the most shocking statistic is, ''up to ten million American children are believed to be exposed to domestic violence annually . . .'' (Perry et al., 2006, p.3). We know that large numbers of children are impacted by abuse and neglect and general stress related to family as well as community violence. We are fortunate that ''only about a third of abused and neglected children in clinical settings meet diagnostic criteria for PTSD'' (van der Kolk, 2002, p. 131), yet that percentage still leaves a significant number of children who meet criteria for a clinical diagnosis which signifies the severe impact of the abuse and neglect they have suffered. McCann and Pearlman (1990) have defined an event to be traumatic when it ''(1) is sudden, unexpected, or non-normative, (2) exceeds the individual's perceived ability to meet its demands, and (3) disrupts the individual's frame of reference and other central psychological needs and related schemas'' (p. 10).

As child protective reports continue to be made and service delivery systems attempt to respond with increasing effectiveness, there is a need to reevaluate programmatic and clinical services. In our Ulster County, New York, clinics, we found complex trauma to be the source of most of our referrals for families where trauma and abuse were present. Judith Herman (1992) and other clinicians and researchers in the field have distinguished the impact of single traumatic events from the more complex, repeated, and prolonged abuse experiences. Herman (1992) has referred to ''complex post-traumatic stress disorder'' (p. 119) to classify this set of symptomatology.

When abuse is repetitive and when it occurs within the context of the family environment, there are implications that go far beyond those of a single traumatic event. As children proceed through their developmental process, they are tasked with learning many skills that set the building blocks in motion for future development. When a child's sense of safety and security is violated, her ability to form a foundation on which to develop future capacities and strengths is severely impaired. Attachment and connection to a secure relationship early in life provide the structure necessary to support healthy child development. When attachments are severed due to trauma, the impact is pervasive. ''Complex trauma exposure results in a loss of core capacities for self-regulation and interpersonal relatedness . . . '' (Cook et al., p. 390). '' . . . Children with complex trauma histories evidence both behavioral and emotional expressions of pathology due to impaired capacity to self-regulate and self-soothe'' (Cook et al., p. 393). The extent to which trauma impacts each individual child, however, appears to vary depending on the developmental stage at which the traumatic events occur. Certain brain regions may be more susceptible to damage at different developmental stages.

Given this perspective, there is complexity to diagnosing and treating child and family trauma. The present *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) includes a diagnosis of posttraumatic stress disorder that presents great limitations when diagnosing children. The PTSD criteria in the manual do not take into consideration the multilayered impact of trauma on the developing child. The Complex Trauma task force of the National Child Traumatic Stress Network has been engaged in an effort to more accurately classify and diagnose children who have experienced the effects of complex trauma. The diagnosis of Developmental Trauma Disorder (van der Kolk, 2005, p. 406) has been proposed. ''This provisional diagnosis is based on the concept that multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence, have consistent and predictable consequences that affect many areas of functioning'' (van der Kolk, 2005, p. 406).

ULSTER COUNTY, NEW YORK

Over the course of the last six years, the Family and Child Unit in the Ulster County Mental Health Department has undergone a radical shift in how services are provided to the community. In 2003, after reviewing both the current caseloads as well as the waitlist referrals, it was determined that the primary reason for referral to our outpatient clinic service was environmental/family dysregulation as opposed to more isolated psychiatric disorders in the child being referred for services. In other words, few children were referred for what we might consider true genetically driven psychiatric disorders. Rather, guardians expressed concerns about a host of behavioral manifestations associated with Oppositional-Defiant Disorder, Conduct Disorder, Post-Traumatic Stress Disorder, and Parent-Child Relational Disorder, which we began to link more clearly to environmental causes. It was at this time that we began to explore the etiology of the behaviors and shift our process of conceptualizing the goals of treatment.

We focused special attention on the population of children and families who presented to our clinics with histories of abuse and trauma. We believed that our traditional outpatient clinic model had proven ineffective at providing services to these families who presented as stressed and unable to organize themselves. There were resource barriers (i.e., lack of childcare/transportation) and a general mistrust of the system that often resulted in poor engagement in therapy. For many families, the typical clinic environment was stigmatizing and did not provide a setting where the family's strengths could be identified and general engagement supported. As clinicians, we were left with an overall sense of ineffectiveness and acknowledged feeling ill equipped to manage the level of family stress despite our awareness of its significance. We began to review trauma literature and consult with experts in the field to determine the best course of action to improve treatment effectiveness. When we reviewed trauma research and the impact of trauma on the maturing brain, we began to develop new ways of formulating our clinical interventions. The following is a brief overview of the pertinent information about how trauma influences the physiology of trauma survivors.

PHYSIOLOGY OF TRAUMA

There has been a recent proliferation of research on the impact of complex trauma on children. Although it would be impossible to provide a full overview of that research in this chapter, there are a few highlights of particular importance.

The brain is organized quite simply into three parts and two sides. The brain stem, limbic system, and the neocortex form the three vertical parts, while the horizontal view is comprised of two sides, the right and left cerebral hemispheres (Stien & Kendall, 2004). This triune brain develops in a hierarchical fashion with the brain stem maturing first followed by the limbic system and then the cortex/neocortex. Each region of the brain is responsible for performing and monitoring various bodily functions. The brain stem works to regulate basic cardiovascular functions and level of arousal, while the limbic system provides a host of other functions. This region of the brain monitors incoming stimuli, stores memories (particularly fearful ones), activates the fight or flight response, and evaluates the significance of experiences. It is also in the limbic system that conscious and unconscious information is transferred between the two hemispheres. The cortex/neocortex, the third region of the brain, is where planning, conscious thinking, and reasoning occur. The cortex plays a role in inhibiting the more emotional, impulsive parts of the brain as well as supporting the ability of the child to connect with others and to find pleasure in those connections and interpersonal exchanges (Stien & Kendall, 2004).

As stated earlier, traumatic experience impedes the hierarchical process of brain development. While the brain matures, it requires each region to develop its unique capacities in order for all the regions to work in concert with one another and to integrate experiences in a coherent, well-regulated manner. ''When these various modalities—areas of the brain—work cooperatively to synthesize experience, intellectual and emotional capacities flourish and consciousness expands. In contrast, when modalities splinter off and function independently, we feel at war within ourselves'' (Stien & Kendall, 2004, pp. 35–36). Typical brain development involves the cortex managing the impulses and emotional responses of the limbic system, specifically the amygdala. The amygdala is conditioned to be the alarm system of the brain signaling the need to act or defend oneself. When chronic trauma occurs, there is a lack of cortical stimulation along with an overstimulation of the limbic system resulting in behavioral dysregulation (Morse & Wiley, 1997, pp. 33–34). When this occurs, the cortex remains underdeveloped or impaired and is unable to perform its regulatory functions resulting in poor impulse control and problem-solving capacities. When abuse or neglect severs a child's secure attachments, an internal sense of disconnectedness is experienced along with the profound impact on the developing child's brain. Schore's research (1994) suggests that as attachments form and reciprocal interactions occur there is an increase in dopamine in infants that ''trigger a local growth spurt in the blood vessels, neurons, and glia of the prefrontal cortex especially in the early maturing right hemisphere'' (p. 134). As infants develop and early maturity occurs, the importance of nurturing relationships on the child's cortical development cannot be overstated.

The most rapid period of overall growth of the human brain occurs between birth and 33 months of life (Morse & Wiley, 1997). ''The right hemisphere is dominant in its activity and development during the first three years of life. . . . If a child has had little resonance of the activity of his right hemisphere with that of his caregivers during the first three years of life, an underdevelopment of that hemisphere's functioning may result'' (Siegel, 1999, pp. 187–188). ''Given that the right hemisphere generally mediates negative emotions, it is not surprising that the memories associated with traumatic experience seem to be stored there'' (Stien & Kendall, 2004, p. 34). The right hemisphere and its primary functions of processing nonverbal communication, managing negative emotions and maintaining body awareness and visual and metaphorical thinking, is particularly susceptible to the impact of the emotional experience of trauma. As Levine (2007) and others have noted, ''trauma is not in the event itself, rather, trauma resides in the nervous system. . . .'' (p. 4). ''. . . Trauma resides in our biology, not primarily in our psychology'' (p. 113). Given this, trauma affects our core functional capacities and has a profound impact on how children perceive the world, read nonverbal cues, and attach to other human beings.

While the right hemisphere suffers limitations due to early lack of attunement, there is also concern about left hemisphere growth lag (Teicher, 2000, p. 58). Teicher (2000) found left cortex underdevelopment in abused patients that appears consistent with findings ''that abused patients had increased left-hemisphere EEG abnormalities and left-hemisphere (verbal) deficits'' (Teicher, 2000, p. 58). The implication is that left hemisphere structure may be impacted by abuse even as right hemisphere limbic region overactivation occurs. This leads to children who are emotionally aroused and limited in their more logical, verbal, rational capacities. Behavior is then determined by emotion rather than logic and reason. These children will have difficulty verbally communicating while becoming emotionally labile and dysregulated.

> . . . During exposure to the traumatic scripts, . . . subjects demonstrated heightened activity only in the right hemisphere, in the areas that are most involved in emotional arousal. . . . Perhaps most significantly, Broca's area—the part of the left hemisphere responsible for translating personal experiences into communicable language—''turned off''. . . . These findings indicate that PTSD patients' difficulties putting feelings into words are reflected in actual changes in brain activity. (van der Kolk, McFarlane, & Weisaeth, 1996, p. 293)

Another important finding is that, ''Traumatized children have . . . been found to have asymmetric brain abnormalities and altered development of their corpus callosum, the band of tissue that allows for interhemispheric transfer of information'' (Siegel, 1999, p. 54). Without fluid exchange of information between the right and left hemispheres of the brain, a coherent narrative of an event cannot be developed. Recent research has suggested there may be some gender differences in the level of impairment of the corpus callosum and specific precipitants to the impairment. Research has shown, ''. . . in boys, neglect exerted a far greater effect than any other type of maltreatment; physical and sexual abuse exerted relatively minimal effects. In girls, however, sexual abuse was a more powerful factor. . . .'' (Teicher, 2000, p. 59).

The alterations in the corpus callosum, along with the impairments in the development of the two hemispheres, lead one to question whether a child can learn to effectively integrate the trauma experience. As stated, the ability to verbally describe the abusive experience is limited by the alteration of the corpus callosum, as communication between the nonverbal, emotional brain and the more verbal, rational brain remain out of sync with one another. Integration of the cognitive and affective components of the trauma experience often does not occur. It may, therefore, be a challenging task for a child to *verbally* describe an abusive event while emotionally overaroused by its impact. ''When information moves from one area of the brain to another, we are actually processing experience through different modalities—sensory perceptions, images, thoughts, behavior, and sensations. . . . The essence of symptom resolution involves the processing of information through all modalities of human experience'' (Stien et al., 2004, pp. 35–36). Full processing of traumatic experience is, therefore, an important treatment focus.

In addition to the various previously noted impairments, there are many others that have been written about in the literature. Briefly, there is also concern regarding hippocampal impairment leading to memory consolidation problems and limitations in memory storage and development of explicit, conscious memory of events and emotions surrounding the events (Siegel, 1999). There are also a host of neuroendocrine, nervous system, and stress hormone implications to chronic stress and trauma that impact bodily functions and brain structural development.

THE TRAUMA SYSTEMS THERAPY APPROACH

The Trauma Systems Therapy (TST) model (Saxe, Ellis, & Kaplow, 2007) has been developed with a core understanding of the physiological implications to complex, chronic trauma mentioned herein. The model is an innovative family and community-based treatment approach focusing on providing targeted clinical and case management services to effectively intervene in the lives of children and families who have experienced trauma. A clinical lens through which to see the child and family is created to support clarity in clinical interventions. TST provides a framework for intervention in trauma systems. ''A trauma system is comprised of (1) a traumatized child who has difficulty regulating emotional states and (2) a social environment and/or system of care that is not able to help the child to regulate these emotional states'' (Saxe et al., 2007, p. 6). Emotional and behavioral dysregulation in the child and family system is the target of intervention. As traumatic stress builds, a child's capacity to self-regulate is compromised. Children with traumatic stress often react to stimuli by rapidly moving from a calm state to one of extreme emotion. LeDoux (1998, 2002) has written about two emotional processing systems of the brain. The ''low road'' and the ''high road'' are descriptive of how information is processed contingent upon the material being taken in. The ''low road'' goes directly to the amygdala, which prepares the body for immediate, emergent response. The information is not contextualized and important details are often missing in order to provide for quick action. The ''high road'' travels to various cortical areas of the brain where more in-depth evaluation of the material occurs in order to provide the amygdala with a fuller understanding of the level of urgency of a situation. This form of information processing leads to more adaptive responses. In TST, these emotional processing systems are referred to as survival circuits. Survival circuits work to ensure survival in dangerous, threatening situations. Children who have lived in chronically threatening environments for long periods of time engage these systems regularly in order to assess the level of danger and react accordingly with perceived life-sustaining responses. However, when the survival circuits are engaged and utilized during situations that are not life threatening, traumatic stress is present. This explains why a child who hears a loud noise in the back of his classroom from another student's book dropping on the floor, stands up from his desk, turns around quickly, and moves to defend himself from that student. Even though this was a benign event, the child responds as if the situation were life threatening. Loud noises have come to represent potential threat to this child after years of abuse and neglect at home where noise often signaled impending danger. As Bessel van der Kolk (2002) stated, ''In PTSD . . . the frontal cortex is held hostage by a volatile amygdala. Thinking is hijacked by emotion. People with PTSD are very sensitively tuned to respond to even very minor stimuli as if their life is in danger'' (as cited in Levine & Klein, 2007, p. 11).

TST attempts to assess a child's use of survival circuits and maps out the four phases of self-regulation. The TST clinician works to identify the trigger of an emotional response and the subsequent phases of a child's emotional state regulation. As the clinician obtains information from a series of events, themes develop as to the child's response patterns. The goal is to utilize psychotherapeutic and psychopharmacological interventions to lengthen the period of time between trigger and response. Cognitive structures can be strengthened and environmental supports enhanced to reduce reactivity.

As stated, the model has been informed by present-day trauma research and its impact on the developing brain, attachment and self-regulatory literature, as well as various models of treatment. In particular, Bronfenbrenner's (1979) social-ecology model of human behavior has served as a foundation to create a treatment approach that values the child's social ecology. Working individually with a child without taking into consideration levels of social ecology will prove ineffective. ''When interventions are conceived that directly address the social environment and system of care and are specifically focused on the child's core problems in regulating emotional states, there is a much higher likelihood of effectiveness'' (Saxe et al., 2007, p. 12).

When a clinician begins work with a child and family, the Trauma Systems Therapy Assessment Grid is completed to determine the initial phase of treatment. The Assessment Grid determines the fit between the child's self-regulatory capacity and the social environment's ability to assist the child with those capacities. This bidimensional assessment results in the child's placement in one of the five phases of treatment. Intervention is then determined based on the phase in which the child is placed. The interventions are therefore constructed based on the child's regulation capacity in direct relationship to the caregiver's ability to attune and be present to support the child's self-regulation. The child's emotional and behavioral regulation state is rated along with the environment's level of stability on the continuum from stable to distressed or threatening. The modules of treatment and the interventions are then chosen to target the areas identified. The TST grid (see Table 7.1) determines the phase of treatment, and the phase of treatment determines the appropriate modules and subsequent interventions used (see Tables 7.2 and 7.3). The modules of treatment span from stabilization (including engagement) to advocacy and emotion regulation as well as cognitive processing, meaning making, and psychopharmacological

Table 7.1
TST Assessment Grid

		Social Environmental Stability		
		Stable	Distressed	Threatening
Regulation of Emotion	**Regulated**	Transcending	Understanding	Enduring
	Dysregulation of Emotion	Understanding	Enduring	Stabilizing
	Dysregulation of Behavior	Enduring	Stabilizing	Surviving

Table 7.2
Phase Intervention

Phase Number	Phase Name
1	Surviving
2	Stabilizing
3	Enduring
4	Understanding
5	Transcending

interventions. The intensity and duration of the interventions depend on the phase in which the child and family begin treatment and the safety factors present in the environment. The clinical work spans home-based, community interventions to the more traditional office-based work depending on the phase of treatment. Although progress through the phases is not always linear, typical treatment length involves approximately three months per phase. Once the phase of intervention is established, priority problems are identified. The initial task of the TST team is to begin to build a therapeutic alliance with the family and to identify any obstacles to engagement. While this alliance is being created, the team begins to provide psychoeducation about the impact of trauma on the child and family. Engagement occurs as the family works toward the identification of its source of pain, and alignment builds as the identified problems are agreed upon by the family and clinician.

Table 7.3
Treatment Modules

TST Phase	Surviving	Stabilizing	Enduring	Understanding	Transcending
TST Module:					
Stabilization On—Site	***	***	—	—	—
Services Advocacy	***	**	*	*	*
Emotion Regulation	*	**	***	—	—
Cognitive Processing	—	—	—	***	—
Meaning Making	—	—	—	—	***
Psychopharmacology	**	**	**	*	*

*** Essential
** Often Helpful
* Occasionally Helpful
— Not Used or Contraindicated

The priority problems are created from an understanding of the patterns of links between the environmental stressors and the child's dysregulation. The identification of the source of pain, or the self-identified problem that each family member seeks to change, serves to motivate engagement in the treatment process. When the family is in the acute, stabilization phase, most of the intervention occurs in the home and community due to the intensity level and the need for crisis support. When the family environment stabilizes, the interventions can move toward more office-based clinical work. At this time, the child is more available for the skills-building, cognitive interventions. These interventions include a variety of experiential, hands-on activities that focus on building emotion regulation and cognitive coping skills. The skills serve to support greater mastery over emotions and insert cognition into the trauma experience allowing for greater understanding and meaning making. Play and expressive arts are relevant in these phases of treatment as they support engagement, learning, and integration of experience.

PLAY THERAPY HISTORY AND RATIONALE

Play is a medium that naturally engages children as well as many adults. Play can be used to build rapport, facilitate engagement, support assessment, or as a treatment intervention. Play therapy, as defined by The Association for Play Therapy (2001), ''is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development'' (p. 20).

Vignette 1

Five-year-old Emily is disrespectful to her mother and refuses to do what her mother asks of her. Her mother yells at her and hits her angrily. Emily is hurt and upset as she has just been narcissistically injured. She retreats to her room and, after crying for a short period, begins to play with her dolls and stuffed animals. As the play develops, one of the stuffed animal characters begins to be mean to the youngest baby doll, and the doll is given a time out for ''saying 'no' to me too many times and forgetting that I'm the boss here.'' After much anger, the baby doll looks sad and frightened and the stuffed animal begins to feel bad and hugs the baby doll. She apologizes, and they then sit quietly together and read a book to calm down.

Vignette 2

Four-year-old Dylan is in the family car being driven down a rural road, when a deer suddenly runs out in front of the car. His mother tries to stop the car before hitting the deer, but is unsuccessful. The deer is struck and killed while the boy watches intently. He and his mother call the police and drive home in tears, feeling sad for the deer left on the road. Two days later, Dylan is playing with his animal collection and a miniature school bus. While driving the children home from school, the bus strikes an animal on the road. The bus driver pulls over and calls the rescue squad. Once the squad arrives on the scene, they help the bus driver to care for the animal until the ''animal doctor'' can arrive to ''fix'' the animal and make sure the animal will be all right.

These brief vignettes reveal the powerful process inherent in a child's play. These rather typical life events are meaningful to children and often impact them in ways that are unknown to the adults around them. Even when events are not overly traumatic in nature, children play out their experiences, and the play allows them to process life events in a manner that is tolerable to them. Recreating a scene in a controlled manner enables children to search for some type of mastery over a situation that in some way threatens their sense of self or security in the world around them. These vignettes show how typical elementary-age children process material through a medium that is natural, safe, and engaging to them. ''It is a beautiful thing to see a child thoroughly absorbed in his play; in fact, it is hard to think of a purer, more spiritual activity. Play brings joy, contentment, and detachment from the troubles of the day . . .'' (Arnold, 2000, p. 35).

Schaefer (1980) noted that in 1920, Hermine Hug-Hellmuth began using play as a tool to diagnose and treat childhood emotional problems. This new form of child therapy grew slowly during the next few decades until the 1940s when ''Virginia Axline introduced play therapy into the mainstream of psychotherapy . . .'' (LeBlanc & Ritchie, 1999, p. 19). As the field progressed, there became a greater understanding of the dynamics of play and the purpose of the activity. Dr. Schaefer stated, ''Based upon a review of the literature (Schaefer, 1993), I have found 25 therapeutic powers of play to have been mentioned most often. ''Play has the power not only to facilitate normal child development but also to alleviate abnormal behavior. . . . In play, children can slowly mentally digest and assimilate traumatic experiences by reliving them with an appropriate release of affect'' (Schaefer, 1993, p. 38).

Chethik (1989) makes an important point about the use of play in therapy: ''Play, in itself, will not ordinarily produce changes. . . . The therapist's interventions and utilizations of the play are critical'' (p. 49). Gil (1991) adds, ''. . . the clinician must serve as a participant-observer, rather than a playmate . . . play in therapy must be facilitated by an involved clinician in a meaningful way'' (p. 28). ''The child's play activity is not simply a recollection of past experience but a creative reworking that combines impressions and constructs forming new realities addressing the needs of the child. . . . Through play, children develop combinatory imagination, that is, the ability to combine elements of experience into new situations and new behaviors'' (as cited in Russ, 1999, p. 61).

In contemporary clinical practice, play therapy has begun to blossom as a distinct specialty in the field of child and adolescent therapy. Within this field, research has begun to support its effectiveness. Clinicians in the field have become clearer about the impact of this child therapy modality as researchers have begun to conduct more studies while also analyzing comprehensive data to search for evidence of its clinical utility. Ray (2006) stated that meta-analytic methodology is used to determine treatment model efficacy by combining results from individual studies to produce an overall effect size. Ray (2006) provided an overview of a large meta-analysis on play therapy that was conducted by Ray, Bratton, Rhine, and Jones, (2001) and elaborated on by Bratton, Ray, Rhine, and Jones, (2005). This meta-analysis was based on data from 93 experimental studies from 1942 to 2000. It was determined that children receiving play therapy interventions performed .80 SD higher than those who did not receive this intervention. In addition ''. . . Play therapy has been demonstrated to improve the self-concepts of children, decrease anxious behaviors, lessen externalizing and internalizing problem behaviors, and increase social adjustment'' (Ray, 2006, pp. 152–153).

COGNITIVE BEHAVIORAL THERAPY

Cognitive behavioral therapy is an approach that emphasizes thoughts, beliefs, and the assumption that people actively shape their own environment. Maladaptive behavior is viewed as resulting from faulty cognitions; therapy focuses on eliminating these cognitions and replacing them with thoughts and self-statements that will promote more adaptive behavior (Kazdin, 1991, p. 96).

A complete review of the research on cognitive behavioral therapy (CBT) approaches for children is not possible at this time, yet this approach has yielded a great deal of empirical support through a fairly extensive research base. The main focus of CBT is on enhancing behavioral responses while shifting cognitions and irrational thought processes. As stated earlier, perceptions and cognitions often become skewed after chronic trauma. These faulty assumptions result in a variety of maladaptive behavioral patterns that become the focus of the cognitive behavioral interventions. In the psychotherapy field, a variety of terms are used to describe specific behavioral and cognitive behavioral techniques and approaches. A few of these include systematic desensitization (Wolpe, 1958); flooding and implosive therapy (Stampfl & Levis, 1967); EMDR (Shapiro, 1991); Rational-Emotive Therapy (Ellis, 1984); Cognitive Therapy (Beck, 1976); Self-Instructional/Stress Inoculation (Meichenbaum, 1974); and Thought Stopping (Wolpe, 1958). Each approach carries a clear goal of modifying behavioral patterns. Given that a large number of the referrals made to child outpatient clinics are for children identified as behaviorally dysregulated, these methods are clearly deserving of exploration.

Cognitive behavioral interventions have been utilized extensively in the treatment of trauma-induced symptoms. As an example, Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006) emphasizes nine components including psychoeducation, parenting skills, relaxation, affective modulation, cognitive coping and processing, trauma narrative, in vivo mastery of trauma reminders, conjoint child-parent sessions, and enhancing future safety and development. The later phases of TST utilize techniques discussed by Cohen and her colleagues to attempt to enhance cognition.

RATIONALE FOR UTILIZING COGNITIVE BEHAVIORAL PLAY THERAPY FOR TRAUMATIZED CHILDREN

Expressive arts and play therapy techniques can be effective at supporting a process of healing. The use of expressive, nonverbal mediums can provide an avenue to address behavioral and emotional symptoms while continuing to be mindful of the physiological changes that occur when children have been exposed to traumatic events that have led to PTSD (Hansen, 2006, p. 76).

As stated earlier, when children have been impacted by trauma, impairments in a variety of functional areas often follow. Impairments in emotional and behavioral self-regulation capacities, diminished ability to attune to self and others, and difficulties with interpersonal relationships are often present along with cognitive distortions and misperceptions of the world. Information processing can be skewed and memory and information retrieval altered. The use of play therapy along with a variety of expressive arts can help children access traumatic material, while thoroughly processing its impact resulting in fuller integration. After re-enacting abusive events or aspects of those events in a safe environment while defending less against the material, the child has an opportunity to develop a more organized, rational behavioral response to the experience. Once the material is accessed through play, there is a chance to introduce verbal, cognitive techniques to decrease the magnitude of the affective response and reduce impulsive behavioral patterns. Prior to this level of processing, the emotional components of the event are often not integrated with the cognitive components thereby making it difficult for the child to verbally communicate about the experience. Traditional talk therapy is rendered ineffective in this situation.

This same difficulty is not present when the clinician requests that a child engage in play therapy. Play sets the right hemisphere in motion by accessing nonverbal, metaphoric material in a manner that bypasses a need for full left hemisphere involvement in the way that talk therapy requires. In addition, play, by definition, is a way that children process emotionally laden material having the capacity to engage and align with the limbic system's emotional and impulse-driven process. As play therapy evolves, and children begin to develop a sense of control and mastery over the material, it appears that a natural, innate evolution toward greater left hemispheric and cortical involvement by the child occurs. This shift allows for the development of the more analytic, planning, and problem-solving skills to develop. Prior to initiating play therapy, more rational, logical thinking may be limited as the emotional regulation issues take such prominence. Children have difficulty thinking clearly when they are being ruled by their emotions. Given that the limbic system develops prior to the cortex, much of early traumatic experience is emotionally stored without being cognitively integrated. It therefore stands to reason that play can allow the processing of emotionally laden material free of the pressure to talk about the event of which the child may have no conscious awareness. Once the information is accessed, children can be supported to integrate new cortical, cognitive skill sets. ''Cognitive-behavioral psychotherapy, which emphasizes correcting illogical, self-defeating perceptions, may work by strengthening left-hemisphere control over right-hemisphere emotions and impulses'' (Teicher, 2000, p. 65). The combination of play therapy with sequenced cognitive behavioral, skills-building therapy may have the potential to be an effective treatment strategy for this population.

Margaret, a 10-year-old girl, was referred to outpatient mental health therapy after being discharged from her third psychiatric hospitalization for suicidal ideation and aggression toward herself and others. She resided in a foster care setting due to her mother's inability to contain her aggressive behavior toward family members in her home. Her acting-out behavior dated back to her disclosure of alleged sexual abuse by a relative. There was very limited information about the extent or duration of the abuse as her former therapy relationships appeared to fail to engage her, which resulted in a lack of participation in the therapy process. Her verbal skills were limited, and she had little motivation to engage.

During the first few sessions, I attempted to align with her through the use of play materials and by making few demands for any verbal interaction unless initiated by her. Surprisingly, she was quite engaged during the first two sessions. This changed however during the third session, when she presented with a great deal of anxiety and refusal to speak. She struggled to sit still in her chair, was unable to focus, and her breathing pattern was erratic. In hopes of supporting self-direction, I decided to disclose my concerns about her presentation and acknowledged my confusion about what we should do during the session. I asked her to try to use the session time to help her calm down. I was particularly concerned about her behavior because it appeared that she presented this way prior to former hospitalizations. Despite her earlier reluctance to engage, she did eventually request to utilize the sandtray. Within the metaphor of sandtray play, she created a scene filled with chaos and fear. Once completed, she fell to the floor and stated, ''I can talk now.'' She then verbally shared about a recent fight with her foster mother that she feared would result in the foster mother requesting her removal from the home. Her negative self-concept and impaired interpersonal relationship skills rendered her helpless to negotiate this situation. Due to her skewed, irrational perceptions, she made inaccurate assumptions. Given this understanding, we then engaged in a variety of role-plays and initiated several problem-solving strategies to create a plan that opened up communication between her and the foster mother. We successfully preserved the foster care placement. She later shared this was the first time she ever had success at talking about a problem before it resulted in acting-out behavior.

By engaging in this play therapy activity, Margaret was able to align with the emotional aspects of her experience without being overwhelmed by its significance. As she successfully initiated this process, the level of emotional overload was de-escalated and she was able to put words to the experience. Once capable of this, she was able to utilize external support to problem solve.

The phrase ''skill building'' or ''skill enhancing'' therapy can be used to describe a form of cognitive behavioral play therapy that focuses on the use of concrete techniques designed to support the creation of internal strengths within the child. These techniques, often focusing on building skills to correct illogical perceptions and ineffective behavior patterns, help children respond to the demands of their environment. Cognitive behavioral and skills-building therapy can provide children with a bag of tricks from which they are able to choose a variety of strategies to respond most effectively to their environment. As TST became integrated into the Ulster County child mental health system, it was clear that these skill-building techniques could be integrated into the model throughout the various phases within particular modules. Table 7.4 identifies the eight proposed skill sets that coincide with the various TST Modules.

I. Grounding
  - Stabilization/Emotion Regulation Module
  - **Sensory awareness in the moment (hear, touch, see . . .)**
  - **Remaining present despite heightened emotional states**

Table 7.4
Areas of Skill Building

Skill Sets	TST Module
I. Grounding	Stabilization/Emotion Regulation
II. Feelings Identification	Emotion Regulation
III. Affect Modulation	Emotion Regulation
IV. Feelings–Thought–Behavior Awareness	Cognitive Processing
V. Impulse Control Regulation	Cognitive Processing
VI. Problem-Solving Capacity	Cognitive Processing
VII. Self-Concept/Identity Development	Meaning Making
VIII. Object Relations/Interpersonal Relationship Enhancement	Meaning Making

II. Feelings Identification
  - TST Emotional Regulation Module
  - Ability to label wide range of feelings

III. Affect Modulation
  - TST Emotional Regulation Module
  - Regulating high levels of strong emotion (anxiety, anger . . .)

IV. Feeling–Thought–Behavior Awareness
  - TST Cognitive Processing Module
  - Ability to identify differences between feelings and cognition and their impact on behavior

V. Impulse Control Regulation
  - TST Cognitive Processing Module
  - **Managing impulses by thinking it through—self-control**

VI. Problem-Solving Capacity
  - TST Cognitive Processing Module
  - **Enhancing ability to solve problems via logical, rational thought, separate from emotional experience**

VII. Self-Concept/Identity Development
  - TST Meaning Making Module
  - **Enhancing overall sense of self and self-empowerment**

VIII. Object Relations/Interpersonal Relationship Enhancement
  - TST Meaning Making Module
  - Increasing sense of personal efficacy in relationship to others and developing empathy

The following examples highlight how various expressive, nonverbal mediums can be used to support the development of these skill sets. As children successfully process therapeutic material, they become increasingly able to develop skills so that integration and stabilization can occur. The following case examples represent four specific skill sets as they relate to the TST modules of Stabilization, Emotion Regulation, Cognitive Processing, and Meaning Making.

Case Example I

Skill I: Grounding

PRESENTING INFORMATION

A 12-year-old girl, Emily, presents with symptoms of agitation, aggressiveness, and difficulty remaining focused when attempting to complete a task. Her mother reports that she has a history of having been verbally and physically abused by her father, who no longer resides with the family. Emily has had no contact with her father during the last three months, yet when anyone mentions his name, she immediately becomes agitated. She becomes unable to sit still, breathing changes occur, and her speech becomes pressured. Emily often becomes aggressive with her mother when limits are set and when she is in a heightened emotional state. She is easily distracted and appears not present at times as if she were ''not on this planet.''

POSSIBLE INTERVENTION/TREATMENT STRATEGY

''Comfortable Place'' ''Anxiety Ladder'':

Part I:

The clinician can request that Emily create an image of a safe or comfortable place. She can draw this safe place or create the image using clay, sand, arts and craft supplies. The clinician can request that she add specifics to the scene, such as things she will see, hear, smell, and feel in the safe place. It is helpful for the image to include as much sensory material as possible.

Part II:

Once this place has been created, the clinician can utilize this image to support the development of a visualization of this image at various times throughout her day. In order to help her begin to use the image during times of heightened emotion, she must begin to develop the skill of visualization while in a relatively calm state. Visualization can be introduced initially into the therapy session and homework assignments can be given for generalization outside of the session.

Part III:

An educational process then unfolds, and skill building occurs with regard to identifying anxiety states and precipitants to her heightened anxiety states.

A definition of anxiety can be created between clinician and Emily. What does anxiety mean? How do you know when you are feeling anxious? A list of precipitants to anxiety can be developed. A list of strategies for managing anxiety can be created as well as a list of supports for her when feeling anxious.

Utilizing a drawing of a ladder or a house or any other visual image where one part of it must be built on top of another part, a chain of precipitants can be identified in order to help Emily begin to understand that there are a series of events that she can identify prior to feeling overwhelming anxiety. For example, the first event (written on the 1st rung of the ladder) might be seeing a particular person. Following this contact, (2nd rung of the ladder) her breathing might begin to become more rapid, her thoughts may begin to race, she may begin to *pace around the house, and then ultimately begin to feel overwhelming anxiety (top rung of the ladder). If she can identify the initial precipitant or trigger and then the subsequent responses to that trigger, she can begin to utilize grounding skills, such as visualization and breathing exercises, to reduce her anxiety prior to the feelings of panic.*

Case Example II

Skill III: Affect Modulation

PRESENTING INFORMATION

A 10-year-old boy, Paul, is referred for therapy by his maternal grandmother who was awarded guardianship of him 12 months ago. She is frustrated by his angry outbursts, which appear to ''come out of nowhere.'' She reports that one minute he is calm and the next minute he is hitting, kicking, and screaming. Paul was removed by the local Child Protection Agency due to allegations of domestic violence in his parents' home. In addition, there were allegations that a paternal uncle sexually abused him during a two-year period of time. These allegations were investigated, and the reports were indicated by the local agency. A finding of neglect was rendered against both parents by the local family court. The maternal grandmother petitioned the court and was awarded guardianship subsequent to this finding of neglect.

POSSIBLE INTERVENTION/TREATMENT STRATEGY

''The Ripped Bag''

Part I:

The clinician can present Paul with a brown paper bag and ask that he draw a picture of a person on the outside of the bag utilizing drawing materials. Paul can then be asked to walk around the room and fill the bag with objects he finds in the therapy room. The clinician must request that he fill the bag as full as possible. Once Paul states he is done, the clinician then gives him one more object and asks him to somehow fit the object into the bag. The idea is that when this object is placed inside the bag, it will probably result in the bag being ripped. The metaphor is meant to present the concept that, if too full, anything will break. This can be compared to when individuals are feeling overloaded they often fail to contain their feelings, experiences, and *thoughts. The result is his explosive behavior that often appears to come from out of nowhere.*

Part II:

Paul can then be asked to think of two or three times when he reacted in an explosive manner and create a list of things that led to his inability to manage the shifting of his behavior, or that resulted in the brown bag ripping. This list can be shared with his guardian in order for her to be able to identify triggers to his outbursts and support his efforts to avoid his dramatic behavioral shifts.

Case Example III

Skill IV/V: Feeling–Thought–Behavior Awareness–Impulse Control Regulation

It is possible for a single intervention to target various areas of skill-set development.

PRESENTING INFORMATION

An angry 16-year-old adolescent, Mario, presents for therapy due to a referral from his probation officer. He has been placed on probation due to a series of events where he engaged in violent behavior toward others. He presently resides in a group home setting. He was placed into foster care four years ago due to allegations made against his parents for substance abuse and physical abuse perpetrated against him by his father. He has difficulty in school both academically and behaviorally. He has a history of being diagnosed with ADHD due to his difficulties focusing and completing tasks. In addition, Paul is impulsive and becomes physically agitated.

POSSIBLE INTERVENTION/TREATMENT STRATEGIES

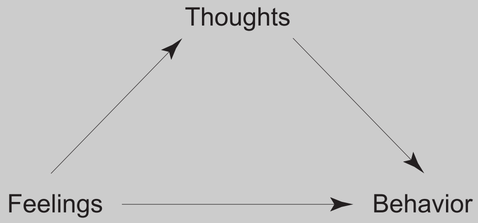
''Think It Through''

Part I:

The clinician can request that Mario attempt to define a feeling and a thought. A discussion can occur regarding the difference between these two terms. Although these terms are used often, few people spend time attempting to define and understand their true meanings. It is during this initial discussion that the clinician begins to highlight the importance of our thought process and how thinking often precipitates behavior. This concept is difficult for adolescents to truly understand as they often respond with a statement of

''I don't know why I did it. I just did. I didn't think about it. I just did it.'' Although adolescents often believe themselves when they make this statement, it is clear that there is a process that unfolds every time they engage in a certain behavior.

Part II:



The figure above, similar to The Cognitive Triangle described by Cohen et al. (2006), can be utilized with Mario to help him visualize the idea that feelings, thoughts, and behaviors are all interrelated. Each one affects the others. Mario can be asked to re-create a recent event in his life and the thoughts, behaviors, and feelings can be outlined with this interrelationship in mind.

Part III:

Mario can be asked to utilize the same event mentioned in Part II and can explore how his behavior might have been different if his thought process or feelings had been different. His feelings might have been different if his behavior or thoughts had been different. For example, if a 16-year-old gets pushed by a fellow classmate who is walking down the hall in the same direction as him, he can choose to push him back or to excuse the fellow classmate's behavior for any reason he might choose. If his thought is ''Who does that jerk think he is?'' he is more likely to feel angry at the classmate and behave aggressively. If his thought is ''Oh he is probably just in a rush,'' he is more likely to feel calmer and less likely to act aggressive. Evaluating his thought process and understanding how thoughts, feelings, and behaviors are interrelated, may help Mario manage impulses more effectively.

Case Example IV

Skill VII: Self-Concept/Identity Development

PRESENTING INFORMATION

A 13-year-old pre-adolescent, Takeema, is referred for therapy by her mother, who shares concerns regarding her daughter's poor self-image.

Her daughter is withdrawn and sad a great deal of the time. She has poor eating habits and has few friends. She spends much of her time alone in her room and often makes negative self-statements. Takeema is not motivated to engage in most activities. Her mother reports that this behavior began shortly after her eleventh birthday when she disclosed that her father had been molesting her several times a week for several years. The father no longer lives in the home, and the mother and daughter have been in therapy off and on since the disclosure.

POSSIBLE INTERVENTION/TREATMENT STRATEGY

''Who I Am''

Part I:

The clinician can provide Takeema with a large piece of newsprint paper and trace a rough image of a human torso on the newsprint. The clinician can provide an array of magazines ranging from teenage magazines to adventure/outdoors magazines that depict people engaging in a variety of activities. Takeema can then be asked to cut out images she finds in the magazine which tell something about who she is. The images can be of people who remind her of herself, things she likes to do, eat or look at, and so on. Once the pictures have been cut out, she can place the images inside the torso that has been traced on the newsprint paper.

This activity is a less anxiety-provoking way of having the young adolescent describe herself. The clinician will then have a fuller appreciation of how Takeema sees herself. The activity can provide a great deal of important assessment and diagnostic information.

Part II:

A range of interventions can follow this activity.

The clinician can request Takeema to verbally discuss some of the chosen images in the torso drawing. ''Tell me what made you choose some of these images? How do they tell me something about you?''

The clinician can request Takeema to choose some additional images from the magazines that represent things that disgust, anger, or sadden her about herself or her life (past, present, or future). She can be asked to cut them out and place them on the same newsprint either outside of the depicted image of the torso, on the back of the newsprint torso image, or on a separate page altogether.

A discussion often naturally occurs subsequent to this activity. The clinician can attempt to process the aspects of Takeema's life that have brought her unhappiness and attempt to externalize or separate those from her as an individual. The separation of these events from herself as an individual often serves to help her feel less burdened and more able to manage her affect.

These activities are examples of how children and adolescents can utilize different play mediums in therapy in order to process and integrate traumatic material. Once engaged in the nonverbal process, verbalization often follows and the child's symptoms and behaviors inevitably improve. Play provides an avenue for processing material in the service of ego development leading to skill acquisition. This chapter supports the belief that within TST, play therapy combined with sequenced cognitive behavioral, skills-building therapy is an effective treatment strategy for traumatized children.

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CHAPTER 8

Incorporating Play within a Manual-Based Treatment for Children and Adolescents with Anxiety Disorders

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CHILDREN AND ADOLESCENTS are not known for their eagerness or even willingness to sit and talk about problems with an adult. Quite the contrary may be true: Children and adolescents are likely to be impulsive, limited in their self-reflection, and nondisclosing in conversations with adults. How then would an adult undertake to implement psychological treatments that include verbal exchanges, learning, working collaborations, and sharing of emotional experiences—with youth? A part of the answer is the fostering of play-related activities as a feature of treatment, in general, and in work with anxious youth specifically. It is not play alone, but play as part of a larger conceptualization of psychological intervention.

Anxiety is a common psychological difficulty experienced by youth, and anxiety disorders having prevalence rates in community samples of youth ranging from 2.4 to 17 percent (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). The several anxiety disorders in youth include generalized anxiety disorder (GAD), social phobia (SP), separation anxiety disorder (SAD), specific phobias, obsessive-compulsive disorder (OCD), and posttraumatic stress disorder (PTSD) (APA, 1994). In this chapter, we focus on treatment for the three main youth anxiety disorders: GAD, SP, and SAD.

Most anxiety disorders do not abate with time and if left untreated are linked to impairments into adulthood. These disorders are associated with difficulties in academic achievement (Ameringen, Mancini, & Farvolden, 2003), social and peer relations (Greco & Morris, 2005), and future emotional health (Beidel, Fink, & Turner, 1991). Anxiety in youth places children at increased risk for comorbidity (Verduin & Kendall, 2003) and psychopathology in adulthood (e.g., anxiety, substance abuse, depression) (Kendall, Safford, Flannery-Schroeder, & Webb, 2004). The consequences of untreated anxiety disorders in youth highlight the need for early intervention.

The results from randomized clinical trials (RCTs) support the utility of child-focused cognitive behavioral therapy (CBT) for treating anxious children and adolescents (e.g., Barrett, Dadds, & Rapee, 1996; Flannery-Schroeder & Kendall, 2000; Kendall, Flannery-Schroeder, Panichelli-Mindel, Southam-Gerow, Henin, et al., 1997). Using the criteria for determining empirically supported treatments (EST) (Chambless & Hollon, 1998), reviews have concluded that child-focused CBT is probably an efficacious treatment for anxious youth (e.g., Albano & Kendall, 2002; Kazdin & Weisz, 1998; Ollendick & King, 1998).

Cognitive behavioral treatment (CBT) combines behavioral strategies (e.g., modeling, relaxation, in vivo exposures, and contingency maintenance) with cognitive strategies (e.g., problem solving, appraisal of personal abilities and perceived threat). In this chapter we describe the incorporation of play-related activities in one structured version of CBT for youth anxiety known as the *Coping Cat* (see Figure 8.1).

THE COPING CAT PROGRAM

The *Coping Cat* program provides a therapist manual (Kendall & Hedtke, 2006a) and uses a child workbook (Kendall & Hedtke, 2006b). The parallel treatment for adolescents is called the *C.A.T. Project* and has a separate therapist manual (Kendall, Choudhury, Hudson, & Webb, 2002a) and adolescent workbook (Kendall et al., 2002b). The programs are 16 sessions and target GAD, SAD, and/or SP, and can be used with other anxiety-related difficulties. The therapist manuals and client workbooks are used together: the manual guides the treatment, whereas the workbook contains client tasks that correspond sequentially with the treatment. For ease, we will refer to the *Coping Cat* program, but the reader is alerted to the fact that much of the content applies to both the child and the adolescent versions of the intervention.

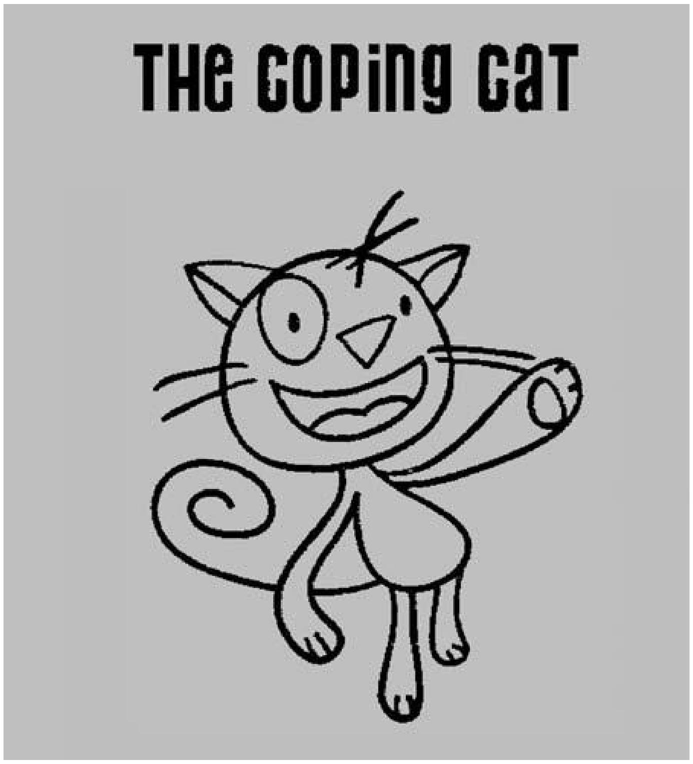

Figure 8.1 The Coping Cat

The *Coping Cat*, as CBT, is a synthesis of behavioral and cognitive strategies, with social and emotional aspects included. That is, cognitive information processing and behavioral avoidance are addressed, as are social influences (e.g., family, peer) and the teaching of emotional management skills. The *Coping Cat* has two segments: the first segment (eight sessions) focuses on psychoeducation, whereas the second segment emphasizes exposure to anxiety-provoking situations. The first eight-sessions provide a platform for a collaborative experience, with the child learning to identify when he[1] is feeling anxious as well as an introduction of strategies to manage and ameliorate anxiety. The various strategies are presented as tools that he may carry with him and draw from when he is feeling anxious. The strategies include: identifying bodily arousal, engaging in relaxation, recognizing anxious thoughts, and problem solving. These skills are taught in a sequence that allows the child to build skill upon skill. The last eight sessions focus on exposing the child to anxiety-provoking situations (using a fear hierarchy) while using and practicing the skills acquired in the earlier sessions.

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[1] The child and adolescent will be referred to in the masculine throughout the chapter to ease readability.

Throughout, the therapist serves as a coach, teaching the child the necessary skills and guiding the child to practice the skills. As part of being a coach, it is important that the therapist not be solely a taskmaster, but also be a model for anxiety management. A good coach is a coping model. A coping model can be contrasted with a mastery model: A mastery model simply demonstrates how to do something (demonstrates success), whereas a coping model demonstrates an initial problem, a strategy to overcome the problem, and then success. In this fashion, the observer gets to see the process of addressing a problem. The therapist can be a coping model by talking about experiences with anxiety, strategies that help one cope with the anxiety, and the reasonably successful results.

THE INCORPORATION OF PLAY

The *Coping Cat* program includes several components that have been considered to be active treatment ingredients. For example, changes in the child's self-talk (Kendall & Treadwell, 2007) and the engagement in exposure tasks (e.g., Hedtke & Kendall, 2007). Although not directly studied, therapists are creative and have fun within the application of the treatment manual and these qualities are likely contributors to the child's participation and involvement, and child involvement has been associated with positive gains (Chu & Kendall, 2004; Braswell et al., 1985). The treatment manual specifically suggests games and fun activities throughout.

The inclusion of play and fun activities provides an age-appropriate method of treatment delivery. It is our belief that learning to cope with anxiety is not book learning that is studied in school. Coming to understand and cope with anxiety in distressing situations is a rational amalgam of (1) experience in the anxious situation and (2) making sense of the experience in ways that will add confidence for coping in the future. Because children rarely self-refer for treatment, engaging youth in the treatment experience carries a special premium. One of the ways to enhance child involvement is through play, defined as interactivity with the therapist that is intended to be pleasurable and engaging, and play is incorporated, to varying degrees, throughout treatment. (See Table 8.1.)

FEAR PLAN

The *Coping Cat* program provides a series of related and sequenced skills for anxiety management. To facilitate the learning and recall of these skills, the *Coping Cat* program presents the steps of anxiety management using a FEAR acronym: F = **F**eeling Frightened? E = **E**xpecting bad things to happen? A = **A**ttitudes and Actions that can help and R = **R**esults and

Table 8.1
Incorporation of Play by Session

Session Number in Coping Cat Manual	Session Content Addressed	Game/Activity	Example
Session 1	Rapport	“Get-to-know-you-game”	Therapist and child take turns asking each other questions
Session 2 “F” step	Identify feelings	“Feelings Charades”	Child and/or therapist act out feelings
Session 2 “F” Step	Identify feelings	“Feelings Dictionary”	Cut out pictures from magazines and write the feeling below each picture
Session 2 “F” Step	Identification physical sensations	“Body Drawing”	Trace life-size “child” and draw physical sensations
Session 3	Relaxation—the difference between tense and relax	“Robot/Spaghetti”	Therapist asks the child to pretend they are either a robot or spaghetti
Session 4 “E” step	Identification of anxious thoughts	“Thought bubble activity”	Together with the therapist, the child fills in the possible thoughts for different cartoons.
Session 4 “E” step	Identification of anxious thoughts	“Guess-what-I-am-thinking”	Act out different scenarios and have the child guess the “self-talk” that is going on.
Session 4	Identification of anxious thoughts	“Thinking traps”	Thinking traps can be explained to children with either stories or practice.
Session 5	Review of coping plan	“FEAR Plan ID”	Pocket wallet-sized index card that can be decorated and kept with the child
Sessions 9–16	Diagnosis: Separation Anxiety	“Hide & Seek”	Parent hides so child can experience anxiety of not knowing where his/her parent is located.

Rewards. First, the child is taught to recognize how his body responds to anxiety. Second, the child learns to recognize anxious thoughts and expectations that he might have. Third, the child is taught ways to combat anxious thoughts and expectations through strategies such as problem solving and coping thoughts. Fourth, the child is introduced to rewarding himself for partial or full success when facing anxiety-provoking situations.

Play is incorporated in the first session to facilitate the formation of the therapeutic relationship. This can be done by playing a get-to-know-you game. In this game the child and therapist take turns answering questions on cards—questions such as ''what is your favorite food'' and ''how many siblings do you have.'' Here the child and therapist learn about each other; it is nonthreatening, not focused on anxiety, and meant to be easy. The therapist is not only invested in getting to know the child but also discloses appropriate information about herself[2] so that the child can learn about the therapist. Also part of the first session, the therapist explains how the program works and the idea of being rewarded for effort. Collaboratively, the child and therapist form a reward system and reward menu.

Throughout the first part of treatment the therapist and child work together to learn about the somatic cues and physiological reactions associated with anxiety as well as the identification of self-talk. In the first step of the FEAR plan, ''F'' Feeling frightened, the child and therapist work to identify different kinds of feelings and their relationship to the body. This is done in a playful manner where the child is actively engaged. The therapist has the flexibility to coach the child according to the child's specific interests. For example, a child who loves to act may engage in a game of charades with the therapist where they each take turns guessing the feeling the other is acting out. Or for the child who likes arts and crafts, the therapist and child create a ''feelings dictionary'' where they cut out pictures from magazines and write the feeling below each picture (see Figure 8.2). The child is taught that physical sensations are associated with different feelings. Mental imagery is used to help the child. When someone is nervous, for example, his hands might sweat and his heart might race. The therapist and child can create a body drawing where the child illustrates what happens in various body parts when someone is feeling nervous. The therapist can explain the physical sensations to the child using developmentally appropriate examples such as feeling nervous may feel like an elephant stepping on your chest or your stomach being wound

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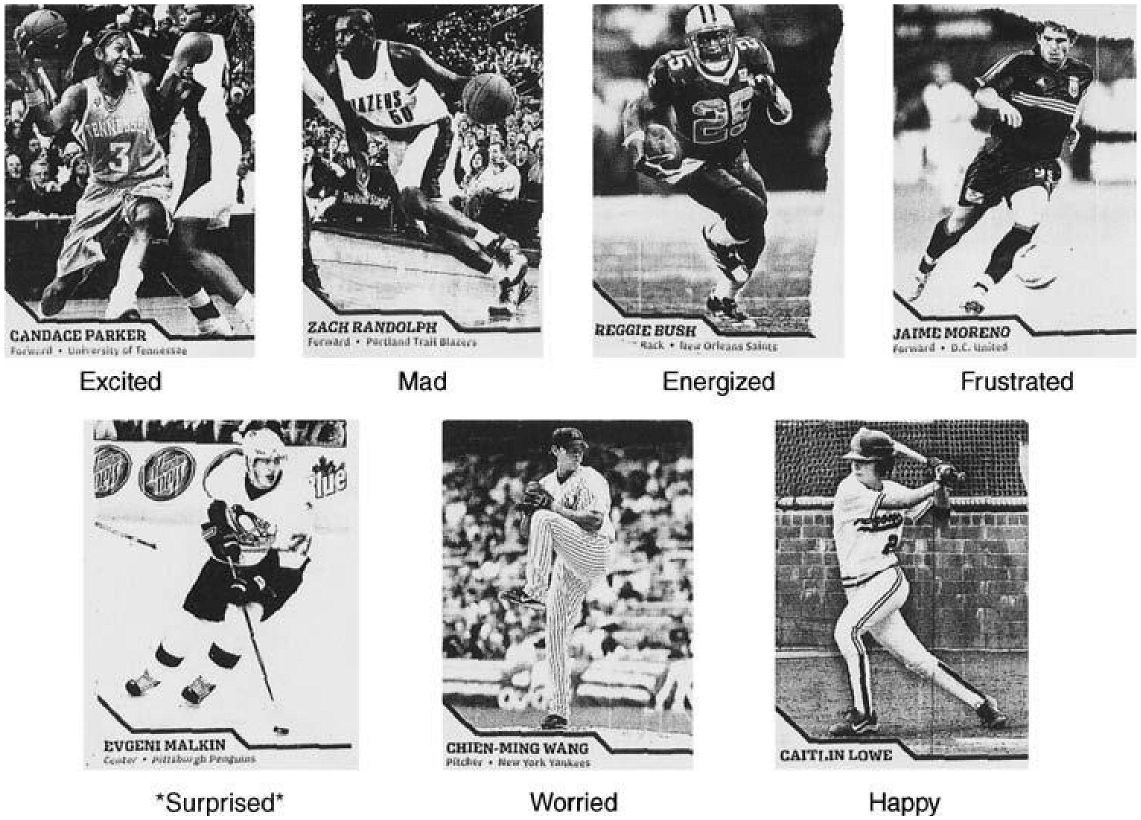
[2] Therapist will be referred to in the feminine throughout the chapter to ease readability.


CANDACE PARKER
Forward • University of Tennessee
ZACH RANDOLPH
Forward • Portland Trail Blazers
REGGIE BUSH
Back • New Orleans Saints
JAIME MORENO
Forward • D.C. United
EVGENI MALKIN
Center • Pittsburgh Penguins
CHIEN-MING WANG
Pitcher • New York Yankees
CAITLIN LOWE

Excited Mad Energized Frustrated

Surprised Worried Happy

Figure 8.2 Sample Feelings Dictionary

up like a ball of yarn. These images help the child understand the somatic sensations associated with anxiety. (See Figure 8.3.)

During the next few sessions the child is taught how tightness and tense muscles contribute to feeling stressed. The feelings and physical sensations the child and therapist identified in previous sessions are used to help the child learn relaxation skills. Again metaphors and mental imagery are used to help engage the child. Physical sensations such as a racing heart or a knot in the stomach can be compared to a thermometer or the body's own fire alarm. When the thermometer gets very hot or the alarm gets very loud this serves as a cue that we are feeling nervous or scared. The therapist teaches the child relaxation strategies to practice when this alarm goes off. The therapist uses play to make these exercises come alive. For younger children the therapist and child act out being a robot with stiff muscles compared to being spaghetti that is loose and wiggly. The child is taught techniques such as deep breathing and progressive muscle relaxation to help their bodies go from a robot to spaghetti. The younger child pretends there are lemons in his hands that he must squeeze to make lemonade. This allows the child to feel tension in his hands and arms, and then he lets the

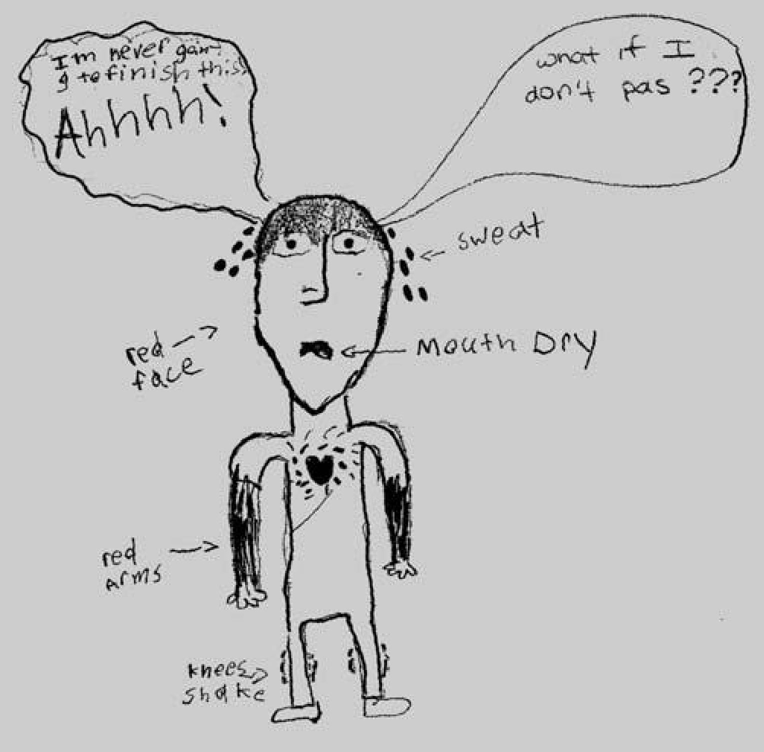


Figure 8.3 Sample Body Drawing

lemons go and his muscles are loose and relaxed. The therapist participates in all of these exercises with the child so that learning can occur in this tag-along fashion, which encourages play and rapport and also can ease the discussion for children and adolescents who find it uncomfortable to discuss their own emotions.

The second step in the FEAR plan is the ''E'' step. Here the child is introduced to the cognitive components of the manual. The ''E'' stands for Expecting bad things to happen. During these sessions the child identifies anxious self-talk (expectations, automatic questions) and learns to challenge these thoughts. Coaching a child through this aspect of the treatment is especially challenging for two reasons. First, the concept of recognizing anxious thoughts is not easy for many children. Specifically, the therapist helps the child begin to recognize his self-talk (expectations, automatic questions, and attributions) in anxious situations. Second, it may not be the most interesting part of therapy for the child, at least not initially. Therefore, being playful and creative enhances the child's interest and allows the learning to be more enjoyable. Flexibility within the manual (Kendall, Chu, & Gifford, 1998) is thought to help develop trust, communication, and alliance.

Being playful in order for the child to understand these concepts in therapy can occur in a number of different ways during the ''E'' step. For example, the child may identify with a certain cartoon character, TV show character, or sports hero. The therapist can obtain pictures or cartoons of these individuals that the child or adolescent finds a special interest in and create a thought bubble activity. Together with the therapist, the child fills in the possible thoughts for different cartoons. Art and drawing can also be added for children who enjoy this and find it easier to talk about themselves and feelings through pictures. Specifically, the therapist can ask the child to draw a picture of himself in an anxious situation and then draw thought bubbles over the picture. In order to adhere to the session content the cartoons can portray fairly simple scenes during which the characters' thoughts are likely to be obvious and include a number of different of feelings.

The therapist and child discuss self-talk, and the therapist facilitates the connection between thoughts and anxious feelings. Play can also be incorporated in the modeling of self-talk. Specifically, the therapist is encouraged to act out different situations where she might be happy or anxious and has the child guess what the therapist may be thinking in those situations. The therapist is encouraged to voice her thoughts out loud. This interactive approach to therapy is especially important for a child who may have distress about his or her own anxiety. As mentioned earlier, drawing and art can provide an outlet to describing a situation when the child does not want to act out a situation or tag along. Child involvement is essential to the therapy, and tailoring the play to a child is essential to maintaining the therapeutic alliance with the child.

A second component of this content area is to discuss thinking traps with children. Thinking traps are common distortions—mistaken ways that children and adolescents with anxiety disorders may think. These thinking traps are usually unrealistic and inaccurate distortions in terms of what is actually occurring in the outside world. There are a number of creative ways that this topic can be introduced. The therapist can encourage the child to be a detective and look for thinking traps that can trick people into feeling anxious before they had a chance to collect evidence. Adolescents can be encouraged to be judge and jury and to demonstrate the evidence for a thought.

There are a series of thinking traps that are discussed in the *Coping Cat* manual. One of the traps is labeled ''Walking with Blinders.'' This label suggests seeing only the negative and overlooking the positive in a situation. Thinking traps can be explained to children with either stories or practice. In practice, the child and therapist can walk around the clinic using their hands as blinders to demonstrate how information is missed. This type of play is especially helpful for children to understand this. A child may also benefit by switching roles with the therapist: Here the child plays the part of the coach or detective and tries to convince the therapist that a situation is unlikely to happen.

The next step in the FEAR plan, ''A'' Attitudes and Actions that can help, introduces the idea that attitudes and actions can influence how we feel. This session focuses on problem solving as a tool to deal with anxiety. The therapist and child work together to come up with a variety of solutions to various situations that provoke anxiety (and non-anxiety). Being playful can begin with applying problem solving to nonstressful situations. Starting with nonstressful situations helps the child understand the concept of problem solving. For example the therapist may ask the child, ''You've lost your shoes somewhere in your house. How might you go about trying to find them?'' The therapist models brainstorming by generating both pragmatic (e.g. ''try and think when you last wore those shoes'') and nonpragmatic (e.g. ''you could search the newspaper and see if they have reported your shoes missing'') solutions. The child then evaluates the advantages and disadvantages of each solution and is soon better equipped to select alternative solutions to problems.

The overall goal of problem solving is to teach children to develop confidence in their own ability to help themselves meet daily challenges. Children are shown that problems are part of everyday life, and they are encouraged to inhibit their initial impulses (e.g., avoidance behavior) and come up with attitudes and actions that can help. Problem solving involves helping the child define and formulate the problem into a workable situation with goals and alternatives.

In the final step of the FEAR plan the child is introduced to rewarding himself for partial or full success when facing anxiety-provoking situations. Session 8 introduces the ''R'' step—Results and Rewards. The child is introduced to the concept of rating performance and rewarding oneself for effort. The therapist talks about self-reward, and the pair discuss the concept of self-rating and being satisfied with one's effort. The child and therapist collaborate on a list of rewards (e.g., going to the movies with friends, getting a new book or game) and specify what is required to earn the rewards.

Rewards are not simply laid out for the youth: Play can be used to make the information more understandable. For instance, the therapist may discuss that a reward is something that is given when you're pleased with the work that was done. Self-rating can also be introduced in a similar manner. For example, the child can be placed in a situation (e.g., answering a question in school, playing a sport) where he learns that he does not have to do everything exactly right but can still be rewarded. Using examples of famous sports icons, such as Michael Jordan, who shot closer to 50 percent than to 100 percent, can help the child relate to this idea. Similarly, cartoon strips may be used in which the character attempts to cope with an anxiety-provoking situation, but is only partially successful.

Review of the FEAR plan is usually done and many times a ''FEAR Plan ID'' can be made, which is a pocket wallet-sized index card that can be decorated and kept with the child. Review of the FEAR plan and highlighting the four-step, easy-to-remember acronym helps remind the child that fear is manageable. However, it is essential to remember that play helps mold the therapy to the child's interests. For instance, if the child believes that the FEAR plan is boring, it can be adapted to interest the child. As an example, Kendall et al. (1998) stated that the child likes calling it the ''Happy Helper Steps.'' Children have also changed it to ''Kung-fu Kat Kits'' in order to incorporate the steps to their own interests. In this case, the therapist had helped the child formulate words that went with KITS (K = Kat feeling frightened? I = I expect bad things to happen; T = Thoughts and attitudes can help me; S = Special Results and Rewards). The child was able to remember with much more ease since it was a product of his thoughts and imagination. Completing these tasks with creativity and playfulness allows for an increased alliance between the child and the therapist.

EXPOSURE TASKS

The second part of the *Coping Cat* program involves both imaginal and in vivo exposure tasks. During sessions 9–16 the child is given the opportunity to practice what was learned in the first eight sessions of treatment. The purpose of exposure tasks is to create a level of anxious arousal for the child in a supportive environment. The creative exposure task is both effective and memorable for the child. Engaging in situations that are difficult for a child can be made a little less threatening if they have an element of fun. This can be an excellent time to involve members outside the therapy context, especially parents. For instance, a child with Separation Anxiety Disorder may play hide and seek with a parent in order to experience anxiety of not knowing where his/her parent is located. Framing exposure tasks as games and play are important to keep the child engaged. A fun reward may be built into the actual exposure task. For example, a socially phobic child may order an ice cream cone. The child who completes this exposure task experiences both an intrinsic and extrinsic reward.

A valuable exposure task can also incorporate situations where one can play while overcoming fears. For example, a child who is a perfectionist may have an exposure where he draws in the dark, or walks down the street with his shirt inside-out. A child who does not like attention or to be corrected in public may sing his favorite tune in the library or talk loud in a quiet coffee shop (Kendall et al., 1998).

The last part of the program closes with the child contributing to the creation of a personalized commercial about his experiences in the program. The child is asked to put together a video, play, poem, or other creative expression to help teach other children how to manage anxiety. The commercial gives the child an opportunity to teach others what he has learned in a creative and playful way. Commercials have included everything from a rap song to a music video to fictitious newscasts. The child can invite the therapist or his parent to participate in the commercial and props can be used. In the final session the child, therapist, and parent watch the commercial together. The commercial not only offers the child a tangible reward but also may help to buttress maintenance of treatment gains. In the last session the child receives a certificate of accomplishment for his hard work and an end of treatment pizza or ice cream party is held with the child, therapist, and parent.

CONCLUSION

Child involvement in treatment is an important predictor of treatment outcome (Chu & Kendall, 2004; Braswell et al., 1985). Involvement can be facilitated by the use of play. The treatment of anxiety in youth using the *Coping Cat* program encourages a flexible approach to manual-based treatment for anxiety disorder in children and adolescents (Kendall & Beidas, 2007). Change is dependent on involvement, and encouraging play with children and adolescents will encourage participation and rapport during treatment. Treatment of anxiety disorders involves exposure tasks, and because these very tasks may be viewed as challenging for both the child and therapist, rapport and child involvement are essential to successful completion of exposure tasks. Allowing the child to feel anxiety and learn how to cope is essential to improvement. The incorporation of some play activities as a vehicle to involvement and exposure may also allow the child to remember (1) the experience as positive and (2) the tools learned during therapy as part of their coping repertoire. The maintenance of therapy-produced gains may be enhanced when the child has had interesting ways to learn. A collaborative and fun therapeutic environment can be arranged using the strategic incorporation of play within the manual.

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CHAPTER 9

The Role of Play within Cognitive Behavioral Therapy for Aggressive Children

The Coping Power Program

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THE *COPING POWER Program* is an empirically supported, cognitive behavioral intervention for late elementary and early middle school-age children who demonstrate aggressive behavior problems (Lochman, Wells, & Lenhart, 2008; Wells, Lochman, & Lenhart, 2008). Typically implemented in the school setting, *Coping Power* is delivered on a weekly basis to groups of four to six students over an 18-month period. Intervention sessions are manualized and conform to a consistent structure including recurring opening and closing events, as well as session-specific activities designed to deliver material in engaging and interactive ways. *Coping Power* also includes a parenting component, designed to run concurrently with the child program. Given the developmental level of the targeted population, structured play techniques are embedded in the program as effective strategies to present program content.

This study was funded by grants provided by the National Institute of Drug Abuse (DA-16135) and the Office of Juvenile Justice and Delinquency Prevention (2006JLFX0232). Correspondence can be sent to: John E. Lochman, PhD, ABPP, Department of Psychology, Box 870348, The University of Alabama, Tuscaloosa, AL 35487.

Several different structured play techniques are employed in the *Coping Power Program*, including puppets, question-and-answer games, beat-the-clock activities, and role-plays. Other activities are set up as challenges for which successful children can gain winner status or earn prizes or points. The manner in which these activities are presented is key in framing them as play activities. Group leaders who can maintain an atmosphere of fun and enjoyment (and often friendly competition) can best make play out of structured learning activities. There can be a place in the field of child treatment for traditional play therapy techniques, such as nondirective play and drawing activities, when supported by research on the effectiveness of these methods for children with different types of psychopathology (e.g., LeBlanc & Ritchie, 1999; Ray, Bratton, Rhine, & Jones, 2001; Reddy, Files-Hall, & Schaefer, 2005). However, these types of less-structured activities are not included in the *Coping Power* protocol, consistent with the program's psychoeducational and skills-building focus.

In the *Coping Power Program*, play techniques serve several important functions. Play is an engaging way to introduce concepts familiar to children and is often exciting and motivating for them. Children who might otherwise be disinterested in therapeutic concepts are more likely to participate in play activities designed to cover such material. Similarly, children who may be difficult to engage due to diverse issues such as a limited attention span, reticence, an oppositional attitude, or speech/language problems may respond favorably when presented with opportunities for play. For example, a child who is reluctant to volunteer personal examples of anger-inducing experiences may readily do so in the context of a game requiring him or her to provide such examples in response to drawing a card.

Play is also a useful mechanism in maintaining children's interest in therapeutic activities. Repetition is critical in helping children to master new concepts and skills, and by using a variety of play techniques, monotony and the disengagement that is likely to result can be avoided. It is also important to present new information in a variety of ways (e.g., auditory, visual, active practice) to accommodate different learning styles, and play activities broaden the range of available possibilities. For example, a new skill can be introduced through puppet play and active group role-plays. Later, children's comprehension and retention of the material can be assessed (and concepts reinforced) through games in which children answer questions and provide examples of the concept in a game show format.

In a program designed to teach children new skills, practice of those skills is a necessary component of intervention. Using play, children can practice new skills in a fun and nonthreatening way. In the context of a puppet show, for example, children might practice appropriate social interactions with peers. Active group role-plays offer additional opportunities for practice under play-like conditions. Group role-plays also offer additional benefits for social skills-building activities in that they can more closely approximate real peer interactions, thus enhancing generalization. Further, group role-play activities may result in real peer conflicts (e.g., when assigning roles, deciding on a script, etc.), giving leaders an ideal opportunity to model and coach appropriate social interactions.

Overall, we have found play techniques to be useful and important in presenting material, maintaining children's interest, and offering opportunities for active practice of new skills. Following a more complete description of the *Coping Power Program*, including empirical support for its efficacy and effectiveness, the various play techniques employed in the program will be described along with the rationale for these techniques and the desired outcomes.

EVIDENCE-BASE FOR THE COPING POWER PROGRAM

The *Coping Power Program* is a preventive intervention for at-risk aggressive children. This cognitive behavioral program includes a 34-session child component designed to improve children's social cognitions and their positive social and academically oriented behaviors. *Coping Power* also includes a 16-session parent component designed to enhance parenting skills, such as increased parental involvement and child monitoring, setting clear expectations, and providing effective rewards and consequences. The *Coping Power* child component is an expanded version of the earlier empirically supported *Anger Coping Program* (Lochman, 1992; Lochman et al., 1984).

Efficacy and effectiveness studies have indicated in two separate samples that the *Coping Power Program* produces lower rates of delinquent behavior and substance use at postintervention and at a one-year follow-up, in comparison to a randomly assigned control condition (Lochman & Wells, 2003, 2004), and lower self-reported substance use, reductions in proactive aggression, improved social competence, and greater teacher-rated behavioral improvement at the end of intervention, in comparison to children who had not received *Coping Power* (Lochman & Wells, 2002b). Program-induced changes in key target behaviors (e.g., children's expectations about the likely outcomes of aggressive behavior, parents' consistency in their use of discipline) have been shown to mediate the positive effects on delinquent behavior and substance abuse at follow-up assessments one year following intervention completion (Lochman & Wells, 2002a). The *Coping Power Program* has also been successfully adapted for use with aggressive deaf children (Lochman et al., 2001) and with children with clinical diagnoses of Conduct Disorder and Oppositional Defiant Disorder (van de Wiel et al., 2003). An abbreviated nine-month version of the *Coping Power Program* has been found to reduce teacher-rated externalizing behavior problems at postintervention (Lochman et al., 2006).

PLAY COMPONENTS IN COPING POWER

Role-Play Activities

Role-play activities entail the dramatic enactment of real-life situations in the safe context of the therapy setting. The majority of the *Coping Power* child group sessions include at least one planned role-play activity. The purpose of conducting role-play activities is manifold. Cognitive behavioral therapy (CBT) with children has been likened to coaching (Kendall, 2005), in that the therapist's goals are (a) to identify specific behavioral needs and skill deficits; (b) to model specific social and emotional coping skills to address these needs; and (c) to practice and fine-tune the child's ability to successfully implement these skills in increasingly realistic situations. Conducting role-play activities is critical to each step in this process. Role-play activities offer the opportunity for children to try on and practice utilizing specific skills, while in the process of doing so, the leaders gain valuable assessment information about specific child strengths and areas of needed growth.

In the child component of the *Coping Power Program* (Lochman et al., 2008), the leaders seek to simulate challenging real-life situations that the children are likely to face (e.g., being teased by a peer; being bumped into in the hall; being reprimanded by a parent or teacher) and to model how specific coping skills can be utilized to best handle these situations. In doing so, the goal is for the children to gain a deeper understanding of the skill they are learning and the nuances of when and how that skill is best used. Conducting such role-play activities can also help prepare children for barriers they are likely to encounter. Teaching children to anticipate and practice overcoming barriers is a core feature of the *Coping Power Program* and is considered essential to enhancing children's utilization and generalization of skills outside of the intervention setting. The leaders' active involvement in enacting real-life situations may also strengthen the therapeutic alliance by communicating a level of understanding to child clients of the real-life challenges they face.

Several examples will be provided to highlight how role-play activities are used to teach some of the core skills in the *Coping Power Program*. While planned role-play activities are included in most *Coping Power* sessions, leaders are also encouraged to facilitate spontaneous role-plays as they see a need for additional modeling or practice of a specific skill, or if they sense that conducting a role-play could foster a critical teaching moment. Role-plays can include one person playing multiple parts or a number of participants each playing a different part. Role-plays can be very brief, acting out a short interchange, or quite lengthy, taking up a significant portion of the session.

Role-plays to foster emotional awareness. Teaching children effective anger management is a major component of the *Coping Power Program*. Being able to recognize when you are starting to become angry is seen as a critical first step in managing anger effectively. Thus, the initial anger management sessions focus on teaching children to identify the physical changes that occur as they are becoming emotionally aroused. Through discussion, the children generate a list of physiological changes that can happen when you are feeling specific emotions, such as happiness, fear, sadness, and anger. The group members are then asked to generate examples of situations that might elicit each of these emotions (e.g., you might feel afraid if you are about to take an important test; you might feel sad if your grandparent dies; you might feel angry if someone cuts in front of you in line). The students are then asked to take turns acting out the situations generated and identify what changes happen to their body as they become emotionally aroused.

For modeling purposes, the leader goes first (e.g., plays a child who loses her place in line). She asks a coleader or another group member to play the opposing part (e.g., the child who cuts in line). The leader provides some direction to set the scene. ''Let's pretend we are in our classroom lining up for P.E. I will race to the door to be first in line. You play a student who is coming back from the restroom. When you open the door to return to the classroom, you see that we are lining up for P.E. and turn and stand in front of me. We will argue back and forth for a while and then stop the scene.'' After this scene is enacted, the leader shares with the group what clues her body gave her that she was becoming angry (e.g., ''my face started to turn red and feel hot, my head started to spin, and I noticed I was clenching my fists''). To expand the discussion, she might also ask the group members what verbal and nonverbal cues they noticed signaling that she was getting angry.

Next, each child is given a turn to play a character exposed to a similar anger-arousing incident. They can select a situation from the list generated earlier or a real-life situation that they have recently faced. Following each child's turn, the leader asks prompt questions to help the child identify the physiological changes he or she experienced. Both the introductory discussion framing the purpose of the role-play and the follow-up discussion eliciting each participant's reaction and highlighting the take-home lesson are critical. In this session, the leader would make an effort to reflect key bodily cues of anger reported by each child and describe that they will learn in future sessions how to use these clues to identify when they are becoming angry so that they can make better choices about how to handle their anger before becoming too aroused.

Role-plays to practice anger management. Once the group members have learned to identify anger arousal cues, they begin to learn specific skills for managing their anger (e.g., distraction, deep breathing, coping self-statements). Each of these anger coping techniques is first introduced through group activities and discussions. Role-play activities are then used to model and practice each technique. In one of the first sessions on anger management, the group members are asked to generate examples of anger-arousing situations that might be effectively managed by simply distracting yourself or shifting your thoughts to something else. Sample situations might include not being called on by the teacher or learning that you got a bad grade on a test. The group members are then asked to generate examples of ways they could utilize distraction to stay in control in such situations (e.g., counting ceiling tiles, thinking about a fun activity you are looking forward to later in the day, or imagining that you are in a favorite place).

Again, the leader would model the skill first, by playing the person attempting to use distraction to control her anger. It can be useful for the leader to share an appropriate real-life anger-provoking incident to help normalize the experience for the group members. For example, the leader might ask a group member to help act out a situation she recently experienced by pretending that he is the driver of a car that accidentally rear-ends her car, leaving a dent in the fender. As the action unfolds, the leader gets out of her car and starts to use an angry tone with the other driver. Then she starts to regain her composure and finishes the conversation in a more polite tone. After the role-play has ended, the leader shares with the group members that the change in her voice tone occurred as she started thinking about the movie that she was on her way to go see. She decided to focus on getting the information she needed from the other driver so that she wouldn't be late to the movie. Each group member is then given a turn to act out an anger-provoking situation to practice using the distraction technique. Follow-up discussion questions from the leader focus on what level of anger the group member experienced, what he or she did to attempt to control the anger, how well it worked, and what barriers or challenges arose that made it difficult.

Role-play activities are particularly useful in illustrating that different coping strategies are often needed to cope with increasing levels of anger arousal. For example, it would be more difficult for the leader to manage her anger if the other driver in the car accident scene became hostile. As the group members learn additional coping strategies, this scene could be reenacted to show the group leader using more active and intensive coping strategies. For example, in a later session on coping self-talk, the group leader could show her character using active coping self-statements (''at least no one got hurt''; ''he's just being defensive, if I calm down maybe he will too''; ''the sooner we resolve this, the sooner I can get to my movie'') to handle her anger. Then each group member would be given a turn to practice using coping self-statements while enacting an anger-evoking situation of their own.

While role-plays are being enacted, the group leader can serve as a coach (e.g., by whispering coping self-statements in the ear of the target group member or by suggesting other coping strategies to try). The group leader can also provide suggestions between takes and suggest that scenes be replayed until the group member demonstrates an ability to handle his or her anger effectively. It is also important for the leaders to establish rules for the role-play (e.g., no physical contact, no racial slurs) and to stop the action if necessary to make sure they are enforced.

Role-plays to practice social problem solving. Once children in the *Coping Power Program* learn to manage their initial arousal in anger-provoking situations, they begin to learn a model for solving social problems. Role-plays are used in this component of the program to help the group members learn to accurately identify problems, generate a range of potential problem solutions, evaluate the likely consequences of each solution, and enact the best solution. For example, if a group member shares that he was recently bullied on the school bus, the leader would suggest that they reenact this situation in group. First, she would elicit specific details about what happened (e.g., who said what, how did the group member try to handle the situation, what happened next). Then the group would brainstorm a range of alternate problem solutions (e.g., he could ignore the bully; he could have his mom drive him to school; he could tease the bully back; he could tell the bus driver). Next, the group is directed to choose three or four different solutions to act out. They are instructed to keep the action rolling to show the likely consequence of each solution (e.g., if he tells the bus driver, the bully might try to get back at him later; if he ignores the teasing, the bully might find someone else to pick on).

Each group member is given a turn to participate in a role-play to practice solutions to a real-life problem he or she has recently faced. Follow-up discussions after each role-play focus on which solution(s) seemed to work best, whether there are other solutions that might work even better, whether there is anything the actor could have changed about his verbal or nonverbal behavior that might have led to a better outcome. Optimally, the role-play is repeated until the target group member is able to enact one or more adaptive solutions skillfully.

PUPPET PLAY ACTIVITIES

Puppet activities are naturally engaging for children and lend themselves well to therapeutic activities (e.g., James & Myer, 1987). Puppets are useful tools not only for eliciting and maintaining children's interest, but also in encouraging their active participation. Children who may be reluctant to discuss personal issues or practice new skills are often much more likely to do so when given the opportunity to use puppets.

In the *Coping Power Program*, puppets play a key role in the program's anger-management component and are used as a tool to help children practice new skills in a nonthreatening manner. Children can begin to role-play use of skills in a less-threatening manner with puppets first, prior to active and direct role-playing. Puppets are specifically used to help children practice using cognitive self-statements, coping statements, as a tool for maintaining emotional control during frustrating or anger-inducing events. Children either generate their own coping statements or choose from a pregenerated list (e.g., ''As long as I keep my cool, I'm in control,'' ''It's not worth it to get angry,'' ''I'll grow up, not blow up''). Following selection of the coping statements, the program calls for active practice in using this strategy to cope with anger in increasingly real-to-life situations. Practice in using anger management skills in children's group meetings can be a challenge, however, due to the potential for children (who have been referred due to aggressive behaviors) to lose sight of the purpose of the activity and to lose control of their anger. We have found the use of puppets to be effective in helping children depersonalize the anger experience during initial practice with this skill.

A *Coping Power* anger-management activity in which children use puppets to practice cognitive coping self-statements might consist of two coleaders first modeling the skill. The first leader's puppet might comment that the other leader's puppet has ''ugly hair and stinky breath,'' to which the other leader's puppet might state, ''It's too bad she has to act like this. I am not going to let her get to me.'' The second leader might then explain that her puppet could initially feel itself becoming angry by noticing its face feeling hot and muscles tightening. After using coping self-statements, however, the puppet felt calmer and in control of its feelings. The leader would also make the point that the puppet would usually make the coping self-statements silently to itself, but that for practice and demonstration purposes, the statements are being made out loud for this activity.

Next, each child would have an opportunity to practice coping self-statements with the puppets. Each child in the group would select a puppet and one child would volunteer or be chosen to be the first to have his or her puppet be teased. Leaders would verbalize appropriate ground rules, such as ''no cursing, no racial statements, and no physical contact'' between the puppets, and would instruct the students to direct their taunts at the target puppet one at a time. Following each puppet's taunt, the target puppet would verbalize a coping self-statement, with redirection and coaching from leaders as needed. Following the activity, each child would be given an opportunity to discuss his or her puppet's feeling of anger during the activity and how they were able to cope with the teasing overall. Because the taunts are directed toward the puppets and not to the children themselves, children are typically able to complete this activity without becoming emotionally aroused and to gain success with the general enactment of using cognitive self-statements. To truly master this skill, more naturalistic practice is necessary and follows in subsequent anger-management activities in the *Coping Power Program* (e.g., through role-plays). However, the use of puppets is an important first step in acquiring the basic skill and obtaining initial practice in its use.

STRUCTURED GAME ACTIVITIES

By the time children reach school age, games are an important part of their natural play activities. Although most games will have elements of each, they can generally be viewed as either competitive or cooperative. While children typically respond well to the challenge of a competitive activity, cooperative games can also be engaging and offer the additional benefit of promoting group cohesion and the development of positive social skills. Both types of activities are included in the *Coping Power Program*, and examples of each follow.

Competitive games. An early session in the *Coping Power Program* targets children's organizational and study skills, as children referred for behavior problems often have co-occurring academic difficulties. By targeting organizational and study skills, the program seeks not only to promote children's academic success, but also to reduce their level of student-teacher conflict related to problems such as failure to complete and/or turn in assignments. To meet these objectives, students participate in two different competitive activities. For the first activity, children are asked to bring their bookbags to the meeting, but are not given an explanation for this. Once assembled, the children are told that they will be playing a game and that the first person to locate a particular item in his or her bookbag will be the winner. The students are then instructed to find an item common to all (e.g., a pencil, assignment sheet, math homework), and they are timed as they search for the item. Following this activity, group leaders inform the children that they will be competing against the others to see who can organize his or her bookbag the best. After working on this task for several minutes, leaders announce that they will be playing the race game again. Students are timed as they search for a different item and the winner is announced. Leaders then point out how much more quickly students were able to find the item after they had organized their bookbags.

The importance of organization is further emphasized through a second game activity. Each student in the group is given a set of index cards, each of which is one of four different colors and is labeled with a word from one of four different categories (e.g., fruits, animals, sports, vehicles). The students are asked to place the cards ''into some kind of order,'' but are not given further instruction. After the children have had a chance to organize their cards, leaders ask each child to find a particular word, timing each child's efforts. The winner, the child who was able to find the word most quickly, is then asked to explain his or her organizational strategy and how it was helpful in completing the task.

We have also found games to be an effective and engaging mechanism to review program material. Following breaks from the program and at the program's end, review games are planned to assess students' learning and to reinforce their retention of the program content. A very simple board game format is used in which students draw cards and answer questions to progress around the game board. The cards ask for students to recall vocabulary and concepts from the program, as well as to provide examples of and demonstrate different skills. The winner is the first one around the board and may be rewarded with a small prize or bonus points.

Games that are both competitive and cooperative. Two activities in the *Coping Power Program* involve splitting the group into two teams, requiring cooperation within the team while the two teams compete against each other. One such activity falls within the program's social problem-solving component and is designed to help students persist in using their problem-solving skills. Children are likely to become discouraged when their initial attempts to use social problem-solving skills are not successful, and activities are built into the program to both normalize this experience and to improve their perseverance in problem solving. In the ''Blockers and the Solvers'' game, a problem scenario is read to the children, and the first set of students is asked to come up with a solution to the problem. After the first set of students agrees upon and announces their solution, the second set of students is then asked to come up with a ''block'' to the solution, or a reason why the solution will not work. The first set of students then comes up with an alternate solution, which is again countered by a block from the second set of students. The game continues in this manner until one side is unable to come up with additional solutions or blocks. The teams' roles are then reversed so that each has an opportunity to both ''block'' and ''solve.''

A ''Family Feud''-style game is also incorporated into the *Coping Power Program* as an engaging way for students to consider their teachers' perspectives. Perspective taking is addressed throughout the program as an initial step in promoting effective social problem solving. Again, the students are divided into two teams, each of which taking the role of a different family and working together to come up with the best answers to the question, ''What do teachers expect from students in the classroom?'' As the teams come up with answers, they are revealed on a colorful board with dramatic flourish and sound effects provided by the leaders.

Cooperative games. One of the initial goals of the *Coping Power Program* is for participants to develop cohesion within their group and cooperative games are ideally suited for this task. The first group meeting offers two options for group cohesion building. The first involves students playing a modified version of ''hot potato'' in which they pass a beanbag or ball around the group, noting one thing that they have in common with another group member and one thing that is different between them before passing the object along. For the second option, students work together to come up with a group name and develop a poster or logo that defines their group. Both activities offer opportunities for students to have fun while participating together and encourage awareness of commonalities among group members, promoting respect for others and cooperation.

In the social problem-solving component of the program, students are encouraged to consider the various consequences that may result from different choices they might make in response to a problem scenario. For example, when faced with a problem such as being teased by a peer, students might offer the choice of telling the teacher. Leaders would then walk them through the various consequences of this choice, including the possibility that the teasing will stop, the possibility that the teasers will become angry and tease more, and the possibility that the child will earn a reputation as a tattletale. To help students understand the importance of considering consequences before making a decision, the ''Trouble at Sea'' task is introduced. In this activity, students are given pictorial representations of 10 different items commonly found on a ship (e.g., life rafts, drinking water, ship-to-shore radio) and are told that they must dispose of any nonessential items in order to keep their ship, which has encountered bad weather, from sinking. Students work together, discussing the various objects and the potential consequences for throwing each overboard, and come up with a group decision about which items they will keep and which they can do without. The activity highlights the importance of giving careful consideration to the effects of one's choices and also offers in vivo practice in cooperative problem solving and using appropriate social skills.

PARENT-CHILD SPECIAL TIME

A quite different way in which play becomes involved in cognitive behavioral programs like *Coping Power* is through certain aspects of the intervention work with parents designed to literally help the parent play more productively with the child. The rationale for this derives from two rather different conceptual frameworks. First, from an attachment theory standpoint, children with aggressive behavior problems often have maladaptive parent-child attachment patterns. Attachment theory is based on the assumption that parents who are able to recognize and respond in warm, positive ways to their children's emotional needs are more likely to have children who develop secure working models of their relationships (Brinkmeyer & Eyberg, 2003). When children have positive social schemas, based on their working models, they are able to more accurately perceive others' intentions and to be more effective in regulating their emotions. Insecure attachment occurs when parents are intolerant or unresponsive to children's emotional expression and distress, and this can lead to children having poor peer relations, a poor sense of their social competence, weak problem-solving skills, and ultimately to aggressive and antisocial behavior. Thus one function of the form of parent-child special time evident in Parent-Child Interaction therapy (Brinkmeyer & Eyberg, 2003) is to improve the positive attachment between parents and children.

A second conceptual framework used as the basis for parent-child special time is derived from learning theory (Wells et al., 2008). Because of continuing friction and problems between children with externalizing behavior problems and their parents, often caused in bidirectional ways (Fite, Colder, Lochman, & Wells, 2006) with child behavior problems contributing to poor parenting as well as poor parenting contributing to child behavior problems, parents become disengaged from their children, and they are perceived less positively by their children. As a result, the parents lose some of their reinforcement value when they attempt to encourage children's positive behavior. The parent-child special time activity can permit parents to regain some of their positive social reinforcement value and to actually have opportunities to socially reinforce their child.

Parent-child special time is a set time within the therapy session, and then later when parent and child are at home, when the parent will interact with the child in a noncontrolling way, while the child is in a play activity, such as using plastic blocks to build a house. The parent's role is to observe and comment on the child's play behavior, but not to control or criticize it. In families with aggressive children, this type of nondemanding parent-child interaction rarely occurs, and many of these parents require careful training to accomplish this seemingly easy task, and express considerable delight when they do get accustomed to the task. In some parents, it reawakens the joy they experienced with their child years earlier, before problems began to escalate in their relationship.

In our parent group sessions (Wells et al., 2008) we begin this discussion about promoting close parent-child relationships by noting that in addition to the focus on praising good behaviors (parents will have been talking about social learning theory and its assumption that positive reinforcement of competent child behaviors leads those behaviors to occur at a higher frequency), it is also important that parents spend relaxed, nonproblem-focused time with their preadolescent children. Even though children are getting older, and children increasingly are engaged with their peers, it is important that parents realize that they still hold central roles in their children's lives. Parents are the people that they look toward in times of stress and parents continue to be role models for their behavior. In our discussion with parents we indicate that if parent and child have developed a positive relationship with one another, and if the parent nourishes this relationship on a regular basis, it is more likely that the child will continue to look to the parent for support in the future, and the parent will gather increasing power as a reinforcer of the child's behavior. These positive interactions fill up the ''parent piggy bank'' in the child's eyes, and make the child more responsive to the parent's praise of their positive behaviors. We also discuss with parents how maintaining a close, positive contact with their child is an excellent way to counteract the influence of negative social forces in the world around them. Such forces include, but are not limited to, peer groups (gang or other), the media, and negative adult role models. Research has shown that children who maintain close bonds to and positive relationships with their parents are less likely to join gangs or be influenced by negative peer groups and are more able to stand firm against negative peer pressure.

We then ask parents to generate ideas about age-appropriate parent-child activities. Parents are encouraged to think creatively and to try to put themselves in their child's place. Parents are encouraged to think of activities that their child would enjoy rather then think of activities that need to be done for the family (e.g., grocery shopping). We encourage the parents to write down their list of ideas in their folders as a concrete reminder of their plans to schedule and have parent-child special time each day during the coming week (Wells et al., 2008).

The therapist tells the parents that maintaining a positive relationship with their children can often be accomplished with something as simple as making sure that they reserve 10 or 15 minutes per day to be with their children in a relaxed way without a lot of other distractions. For example, the parent could spend 15 minutes a day talking with the child about the child's day. The parent can ask about school, ask about the plans for the week, and simply show an interest in what the child is doing. The parent may want to spend those 15 minutes a day doing an activity together (e.g., playing a fun cooperative game of the child's choice) and talking with one another. In addition, some children this age still like to have their parents read to them, and this is a good way to nourish a close bond between parent and child. The main idea is that the time that the parent spends with their child should not be used for discussing problems or negative behavior. This parent-child special time should be protected and only used for positive interactions. Because the goal is interaction, parent-child sharing time should not involve passively sitting next to one another, such as sitting in the room together and watching television, without interacting. However, an active discussion about a television show could be quite appropriate.

Parents are told that an important aspect of spending time with their child is making sure that the child is interested and involved. The parent hopes to encourage the child to talk and to relate to the parent positively during these times. The clinician then brainstorms with the parents about how to encourage their child to talk to the parent and relate to the parent during special time. The clinician makes sure that the following parent actions are included in the brainstormed list: (1) Praise the child often,

(2) Show an interest—Ask Questions, (3) Do not criticize or reprimand REGARDLESS of what happens, (4) Defer all problems to a later time, (5) Avoid controversial subjects, (6) Have fun just being together, (7) Allow the child to choose the activity, and (8) Participate fully in whatever activity that they choose. The parents are then given a handout that contains this list of reminders for how to keep special time special. To encourage active parent involvement in this discussion, and to assess their degree of acceptance of this task, the clinician periodically asks the parents what they think about having regular, positive contact with their child while doing an activity together or just talking together. The parents can also be asked whether they think that parent-child special time can help to develop and maintain a strong parent-child bond, and why that might be so. If parents are slow to accept parent-child special time, then this provides an opportunity for asking about other ideas parents might have for promoting closer parent-child relations and for encouraging them to give it a try for the next week.

The clinician then works with the parents to set goals for using special time at home during the next week. The parents are asked to determine what activity they would like to engage in with their son/daughter. Parents set a goal regarding the number of times per week that they would like to spend interacting positively with their child. Parents are encouraged to be realistic about frequency and length of time allotted for this activity. The clinician can suggest that this will only last 10 or 15 minutes a day and occur three or four times per week at the beginning. This would be a good start to making a positive change in the parent-child relationship. It would be best if the amount of special time spent together increased over time, but any time together is better than none. Parents are then provided with a special time worksheet in which they set a goal regarding the frequency of the activity at home (e.g., three times per week for one hour; one time per day for 20 minutes). For each day they are to list the activities and the time spent interacting with their child. Parents are asked to keep track of any observations they may have while implementing the special time and to put their comments on the worksheet.

While we have used parent-child special time primarily with preadolescents in our *Coping Power Program*, this same concept has been used in cognitive behavioral programs for younger children as well. Using Parent-Child Interaction Therapy (PCIT) with preschoolers (age 3–6), Brinkmeyer and Eyberg (2003) instruct parents to use these same skills with their child directly in the therapy room, while a clinician looks from behind a mirror and instructs the parent, using a bug-in-the-ear device, in how to engage in appropriate child-directed behaviors. Parents are taught to use PRIDE communication skills (Herschell & McNeil, 2007): *Praising* your child's behavior (e.g., ''you are doing a great job of coloring in the lines''); *Reflecting* the child's statements by immediately repeating the child's verbalization (e.g., ''Oh, I see, the horse is going to be friends with the cow''); *Imitating* or mimicking the child's play (e.g., ''I am going to draw a circle too, just like you''); *Describing* the child's play, stated in a neutral noncontrolling manner (e.g., ''you are driving the car into the garage''); and using *Enthusiasm* by having a lot of inflection in their voice.

As the parents learn these child-directed skills during PCIT, they are also learning to ignore negative behavior and are thus using differential social attention. Parents avoid using commands, questions, and criticisms during special time. The clinician shapes these skills in the parents in early sessions, and this portion of PCIT continues until parents have clearly mastered the skills (providing 10 behavioral descriptions, 10 reflective statements, 10 labeled praise statements, and no more than three questions/commands/criticisms during a session), and then parents continue to do five minutes of this form of special time in later sessions as they are trained in more directive forms of parenting skills.

A form of child-directed interaction play also occurs in the *Incredible Years* program for children aged 2–8 (Webster-Stratton & Reid, 2003). Consistent with the PCIT and *Coping Power* approaches just discussed, parents are instructed in how to follow their child's lead and to follow their child's ideas and imagination. Parents have to learn to pace the play at the speed normal for their child, and often have to slow down because young children repeat the same activity over and over, whether it being playing a game, reading a book, or watching and describing a movie. During these periods of special time, parents have to avoid power struggles and have to avoid becoming so involved in a game that they want to make sure they always win or that they require the child to rigidly follow complex game rules. Instead, parents can engage in activities that encourage make-believe, fantasy and role-playing. During these activities, parents use descriptive commenting and give attention to the child's quiet play. Some of the ''Dos'' that parents learn are (a) follow the child's lead, ''tailgate'' the child, (b) watch carefully what the child is doing and then sit nearby, (c) give the child time to think and explore, (d) serve as an appreciative audience for the child's play, (e) ignore the child's inappropriate behaviors, and (f) imitate the child. Parents also learn a set of ''Don'ts,'' including (a) give a stream of commands, (b) change what the child is doing, (c) try to teach anything during this period, (d) pace the interaction too fast, and (e) impose adult structure or ideas on the child's play. The use of parent-child special time activities in these programs allows parents to develop meaningful skills in being able to enter children's play, and in so doing to strengthen the parent-child bond and to enhance the value of parents' social reinforcement.

CONCLUSION

Play therapy techniques are sometimes presented as being antithetical to cognitive behavioral therapy approaches with children and their families, but it is apparent that play can clearly be used in the service of evidence-based cognitive behavioral therapies. Cognitive behavioral therapy, as illustrated in the *Coping Power Program*, focuses on the development of certain cognitive and social skills that can improve aggressive children's functioning. Critical aspects of intervention with externalizing disorder children are based in methods that permit children to become actively and enthusiastically involved in intervention, and to repeatedly practice skills that they are learning so that the skills can generalize to their real-world social settings at home and at school. Play serves a central role in promoting children's engagement in cognitive behavioral intervention and children's therapeutic alliance with the clinician. It is through play activities that children repeat over and over some of the new skills they learn to regulate their anger, to more accurately perceive other's perspectives, to think of different ways to competently solve their interpersonal problems with peers and adults, and to try out new social behaviors. It is through this repetition and practice that the skills become more automatic for children and more likely to be used in real-world encounters when the children are beginning to feel anger-aroused or threatened. It is only though their prior use of these new self-regulation and social problem-solving skills in the context of play during therapy sessions that this can occur. Cognitive behavioral interventions like *Coping Power* also have the interesting potential for enhancing parents' abilities to more competently play with their children, and in so doing to enhance the parent-child bond and to increase parents' reinforcement value as they reinforce children's newly emerging positive cooperative behaviors. This element of play in intervention can become an integral part of the ongoing interactions between parent and child long after therapy has ended.

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CHAPTER 10

Innovation and Integration

Parent-Child Interaction Therapy as Play Therapy

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It is likely an uncommon occurrence that someone writes about an operant-based therapeutic intervention and play therapy within the same chapter. But, the fact that Parent-Child Interaction Therapy (PCIT) can be discussed from different theoretical viewpoints contributes to its value and uniqueness. This chapter will provide an overview of the history and foundations of PCIT, describe current PCIT protocol, and describe research evidence highlighting its efficacy and effectiveness at reducing disruptive child behavior problems. In addition, a filial model will be described in which PCIT can be used to target specific skills and cognitions that enable parents to be more nurturing, supportive, and understanding of their child.

As initially developed by Sheila Eyberg (Eyberg & Robinson, 1982), PCIT has been emphasized as an operant intervention, with stated objectives of decreasing child disruptive behavior and improving parenting skills. However, Eyberg (2004) has recently stated that early conceptual influences in the development of PCIT were from two early pioneers in play therapy: Virginia Axline (1947, 1964) and Bernard Guerney (1964). In her description of the origin of PCIT, Eyberg (2004) explained that she supported the play therapy goals and techniques proposed by the Axline and Guerney therapeutic approaches, which promoted warmth and acceptance, yet had concerns that the benefits she experienced within the therapy session were not being transferred to the home. Eyberg (2004) asserted that the influences of a third psychologist, Diana Baumrind (1966, 1967), encouraged her to move toward what she believed was the healthiest parenting style: authoritative parenting, which combined nurturing and responsive parenting behaviors with clear communication and firm limit-setting. Finally, the influence of a fourth psychologist, Constance Hanf (1969), encouraged her to develop a training paradigm to teach parents essential skills to realize Baumrind's vision of authoritative parenting. The genius in Eyberg's innovation was to use the structure of a coaching mechanism to teach parents both the skills employed by child therapists (e.g., the nurturing, warmth, and responsiveness that leads to a strong and positive relationship) and the skills needed for managing the child's behavior (e.g., discipline, limit-setting, child guidance). She was, of course, developing a behavioral intervention which directly addressed an improvement in parenting skills and decrease in child behavioral problems, while indirectly strengthening what we now perceive as parent-child attachment. An added benefit of this coaching mechanism is that through a course of therapy, parents not only develop authoritative parenting skills, but also are able to demonstrate and master these skills in vivo, and thus gaining the confidence to maintain skills with their child when they are outside of the treatment room (one of the objectives of Dr. Eyberg in developing PCIT). From these origins, PCIT has consistently been developed and refined over the last three decades so that it is currently one of the more clearly defined child mental health treatments (Brinkmeyer & Eyberg, 2003; Hembree-Kigin & McNeil, 1995).

WHAT IS PARENT-CHILD INTERACTION THERAPY?

PCIT is an intervention founded on behavioral, developmental, and social learning principles. It has been primarily designed for children between two and eight years of age who have some type of externalizing disorders (Eyberg & Robinson, 1983; Hembree-Kigin & McNeil, 1995). The underlying model of change is similar to that of a parent-training program—that is, modifying the way parents interact with their children diminishes child behavior problems, which in turn promotes more positive parenting (Borrego & Urquiza, 1998). However, PCIT is unique in that it incorporates both parent and child within the treatment session and uses live and individualized therapist coaching to change aspects of the interaction that cause dysfunction in the parent-child relationship (which are identified as the source of the child's disruptive behavioral problems).

PCIT is conducted in two phases (see Table 10.1 for an outline of the overall course of treatment). The first phase focuses on enhancing the parent-child

Table 10.1

Overview of the Course of Treatment for PCIT

1. **Intake and Pretreatment Assessment** (1–2 sessions)
    - Standardized assessment measures
        - Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999)
        - Child Behavior Checklist (Achenbach & Rescorla, 2000)
        - Parenting Stress Inventory (Abidin, 1995)
2. **Child-Directed Interaction/Relationship Enhancement** (7–10 sessions)
    - Child-Directed Interaction didactic—PRIDE skills
        - **P**raise
        - **R**eflection
        - **I**mitation
        - **D**escription
        - **E**nthusiasm
    - Avoid critical statements
    - Avoid commands
    - Avoid questions
    - Avoid ‘No – Don’t – Stop – Quit – Not’
3. **Mid treatment Assessment** (1 session)
   Same as pretreatment assessment
4. **Parent-Directed Interaction/Strategies for Compliance** (7–10 sessions)
    - Parent-Directed Interaction didactic—BE DIRECT skills
        - **B**e specific with commands
        - **E**very command positively stated
        - **D**evelopmentally appropriate
        - **I**ndividual commands
        - **R**espectful and polite
        - **E**ssential commands only
        - **C**hoices when appropriate
        - **T**one of voice neutral
    - Giving effective commands
    - Responding to compliance/noncompliance
    - Practicing consistency, problem-solving, reasoning skills
5. **Posttreatment Assessment** (1 session)
   Same as pretreatment assessment

relationship (often described as Child-Directed Interaction or CDI), and the second phase focuses on improving child compliance (often described as Parent-Directed Interaction or PDI). Both phases of treatment begin with a didactic training, followed by a therapist's coaching of parents while they play with their children. Traditionally, the coaching of is conducted from an observation room via a bug-in-the-ear receiver (i.e., a small electronic receiver that looks like a hearing aide and receives a low frequency FM signal transmitted from an adjacent observation room) that the parent wears.

The therapist/coach talks to the parent through the bug-in-the-ear device in real-live time while the parent is interacting (i.e., playing with age-appropriate toys) with their child. Although the therapist/coach is very active in talking to the parent, there is little to no direct communication between the therapist/coach and the child. Parents are taught and required to practice specific skills of communication and behavior management with their children.

As presented previously, in CDI (typically seven to ten sessions; see Table 10.2 for an outline of the CDI portion of PCIT) the primary goal is to create or strengthen a positive and mutually rewarding relationship between parents and their children by modifying the way parents interact with their children. Parents are taught to follow their children's lead in play by

Table 10.2

Child-Directed Interaction (Relationship Enhancement) and Parent-Directed Interaction (Strategies for Compliance)

PRIDE

Child-Directed Interaction/Relationship Enhancement concepts:

Praise Providing a labeled/unlabeled praise for the child's desired behavior will increase the frequency of that behavior.
Reflection Repeating or paraphrasing your child's statement demonstrates that you are listening/understanding what they say.
Imitation Playing with the same toys as your child shows that you care about what they are doing and find it interesting too.
Description Telling your child what they are doing tells them that you are interested and paying attention to what they are doing.
Enthusiasm Conveys excitement and warmth in your child's activity, showing that you care about them.

BE DIRECT

Parent-Directed Interaction/Strategies for Compliance concepts:

Be specific with commands Providing clear and specific commands increases your child's understanding that they will know what you are wanting them to do.
Every command positively stated Tell your child what you *want* them to do, not what you want them to stop doing.
Developmentally appropriate Make sure the command you are delivering is something that your child is able to do.
Individual commands Give one command at a time, multiple commands can be confusing and unclear.
Respectful and polite Using "Please" and "Thank you" encourages your child to also use these words.
Essential commands only Give commands *only* when needed; too many commands can cause problems.
Choices when appropriate Giving choices promotes independent and problem-solving skills in your child.
Tone of voice neutral Keeping your voice calm, at a normal speaking volume, and relaxed demonstrates you are in control.

describing their activities and reflecting their appropriate verbalizations. They are also taught to praise their children's positive behavior, telling them specifically what is laudable about their actions, products, or attributes. By the end of CDI, parents generally have shifted from rarely attending to their child's positive behavior to frequently and consistently praising appropriate child behavior. For example (C = Child statement; P = Parent statement; T = Therapist/Coach statement):

C: (After 10 minutes into a treatment session, Bobby, a 5-year-old distractible and overactive child, is continuing to sit on his chair coloring with markers.)
T: (Statement directed to the parent) Tell Bobby what a great job he is doing of sitting on his chair.
P: (Statement directed to Bobby) ''Bobby, I like that you are sitting so nicely on your chair.''
T: (Statement directed to the parent) That was a great praise; Bobby is more likely to sit in his chair when you praise him like that.

Also, by using more appropriate statements (i.e., the parent praising the child for desired behavior), parents shift from using more controlling or coercive methods of managing their child's behavior (e.g., ''Bobby! Come back here and sit at the table.'') that may inadvertently lead to reinforcement of inappropriate child behavior. Through a series of interactions (therapist/coach prompts provided to the parent), the parent is able to get their child to engage with them in play, begin to reflect their child's speech (i.e., reinforcing appropriate child verbalizations), and to describe the play in a way that conveys their noncontrolling interest in the child's activity. During this time, parents learn to shape their child's behavior by using selective attention. By using this strategy, parents signal their disapproval of their children's inappropriate behavior by strategically withdrawing their attention. Typically, a parent would practice redirecting the child to an appropriate behavior by playing with another toy on the table (modeling the desired behavior) until the child behaves in an appropriate manner. As soon as the child begins to exhibit more appropriate or desired behavior, the parent then praises the desired behavior and re-engages with the child in play. In some instances the child is not aware of what behavior is desired by the parent in order to get their attention. However, in other situations parents let the children know what behavior they want to see by verbally expressing to their child the specific behavior that will regain the parents' attention (e.g., ''When your bottom is in the chair, then I'll be able to play with you''). When the child behaves appropriately again, they are rewarded with their parents' attention and praise. Mastering selective attention provides parents a foundation for obtaining compliance without engaging in forceful or coercive parenting strategies. It teaches parents patience (it is difficult to ignore annoying behaviors), self-control, and that maintaining a positive context for play may not require high levels of parental discipline. Furthermore, it allows the parent the opportunity to pause and reflect on what behaviors are desired of their child rather than immediately responding to negative-seeking behaviors.

In the second phase, PDI (typically seven to ten sessions following CDI; see Table 10.2 for an outline of the PDI portion of PCIT), the primary goal is to teach effective parenting skills for use in managing children's behavior. In PDI, therapists maintain the focus of parents' attention to their children's positive behaviors while training them to give clear, direct commands. Once parents master giving effective commands, they learn to provide praise for compliance, and strategies for dealing with noncompliance. Parents are taught to give a command, count to five, give a two-choice warning (comply vs. time-out), followed by another count to five, thereby giving the child a chance to comply before receiving the time-out. If a child refuses to comply with a time-out (e.g., gets off the time-out chair), parents are taught a strategy to provide children an incentive to comply with the time-out (e.g., removal of privileges, time-out room), and finally to gain compliance (and to follow through) (Hembree-Kigin & McNeil, 1995). Parents are taught to always praise the child's ultimate compliance, even if it takes a long time to obtain this compliance (e.g., noncompliance leads to a time-out, then continues until the child eventually complies with the parent's initial command). By the end of PDI, the process of giving commands and gaining compliance are predictable and safe for both the parents and the child (Eyberg, 1988). Again, parents are expected to practice the skills of responding to child noncompliance (e.g., following child compliance with a praise, administering a time-out) during the treatment session and continue until they master this skill with their child. Toward the end of the PCIT treatment process, parents are usually able to obtain compliance without giving a time-out. However, if they need to give a time-out, it is a comfortable and well-practiced process for which the parent has acquired mastery (see Hembree-Kigin & McNeil, 1995, for a full description of the PCIT program).

IS PCIT AN EFFECTIVE INTERVENTION?

There have been numerous studies demonstrating the efficacy of PCIT in reducing child behavior problems (e.g., Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001; Eyberg, 1988; Eyberg & Robinson, 1982) and maintaining these positive effects up to six years posttreatment (Hood & Eyberg, 2003). Treatment effects also have been shown to generalize to school settings (Funderburk, Eyberg, Newcomb, McNeil, Hembree-Kigin, & Capage, 1998; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and to untreated siblings (Brestan, Eyberg, Boggs, & Algina, 1997; Eyberg & Robinson, 1982). In addition, PCIT also has been shown to be effective for foster parents (Timmer, Urquiza, Herschel, McGrath, Zebell, Porter, & Vargas, 2006; Timmer, Urquiza, & Zebell, 2006). Given the documented effectiveness of PCIT in helping nonmaltreating parents manage their behavior-problem children, recent research has supported similar benefits with high-risk families, including abusive parents (Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson, Lensgraf, & Bonner, 2004; Timmer, Urquiza, Zebell, & McGrath, 2005), families involved in domestic violence (Timmer, Ware, & Urquiza, in press), and kin-caregivers of maltreated children with a history of maltreatment (Timmer, Urquiza, & Zebell, 2006). In addition, there has been research examining PCIT with different cultural and language groups, including Spanish-speaking families (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006; McCabe, Yeh, Garland, Lau, & Chavez, 2005), Native American families (Subia-Bigfoot & Funderburk, 2006), and Chinese families (Leung, Tsang, & Heung, 2007). Finally, recent research has indicated that PCIT can be successfully adapted for children with an Autism Spectrum Disorder (Solomon, Ono, Timmer, & Goodlin-Jones, in press) and appears to decrease trauma symptoms in young children (Timmer, Urquiza, & Zebell, 2007; Urquiza & Timmer, 2008). While the focus of PCIT treatment gains primarily lies in decreasing child behavioral problems and improving parenting skills, the value of enhancing the quality of parent-child relationships suggest a much larger range of applications.

IS A PARENTING TRAINING (PCIT) PLAY THERAPY?

In his book on play therapy, Landreth (1991) defines play therapy as ''a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play'' (p. 14). It appears, from this definition, that the essential elements of play therapy include (a) a relationship between a child and a therapist (or parent/therapist), (b) focus on development of appropriate and safe expression/communication, and (c) the use of the medium of play as a central theme. For the first element, the use of parents as therapist—or filial therapy (Hutton, 2004)—has been recognized for a long time (Guerney, 2000; Guerney & Guerney, 1987). There have been many approaches to train parents to engage in therapist-like activities with their child (Kraft & Landreth, 1998; VanFleet, 1994). Within PCIT, parents are provided direct instruction about how to engage their child and to follow their child's lead (at least through the early portions of PCIT)—similar to what occurs within a traditional play therapy situation. The second portion of this definition—focus on safe and effective communication—is a central tenet to PCIT. As developed by Eyberg (2004), PCIT focuses on changing parent statements and behaviors (i.e., communication), with the expectation that this will then lead to subsequent changes in child behaviors. The final definitional component of play therapy—the use of play as a medium—is also central to PCIT. Throughout the course of PCIT, parents and children play with age-appropriate toys. Specific attention is provided to utilize toys that enhance communication and are collaborative (e.g., Legos, Tinker Toys, tea set), and to avoiding toys which may be used in isolation or cause difficulties in the parent-child play sessions (e.g., competitive games, guns/knives/swords). Because involvement in play activities are generally perceived by both parent and child as positive and enjoyable, sharing such activities within a PCIT session contributes to the overall positive experience that both parent and child convey toward each other. Through these processes, PCIT/filial therapy is generally understood to utilize the experience of child play as a medium to engage multiple other interventions, such as communication, development of warmth, recognition, and acceptance. PCIT further advances the intervention by teaching/training the parent specific relationship skills to utilize with their child. These can be conceptualized either as parenting or child guidance skills or as play therapist skills. In either case, they consist of skills that are contained in most parenting interventions (Lundahl, Risser, & Lovejoy, 2006), are employed by play therapists, and enhance the relationship between a parent and child. In their extensive meta-analytic review of play therapy treatment outcomes, Bratton, Ray, Rhine, and Jones (2005) identified filial therapy as part of their sample. Interestingly, the filial therapy studies they examined yielded the highest effect sizes when compared to other types of play therapy. This resulted in their concluding "this type of approach appeared highly effective in helping change the relationship between the parent and child as well as the behavior of the child" (p. 386).

CAN PCIT INCORPORATE ELEMENTS OF TRADITIONAL PLAY THERAPY?

In order to develop a more effective PCIT intervention, a careful analysis of coaching prompts was undertaken by Zebell, McGrath, and Porter (2001). It became apparent that several different types of coaching prompts were being used and that the various coaching prompts had different functions and contributed uniquely to the overall goals of PCIT. While the overall goals of PCIT continue to focus on ''parenting stress level, parent-child interactional patterns, parenting skills, child disruptiveness, and child compliance'' (Eyberg, p. vii, in Hembree-Kigin & McNeil, 1995), an additional objective became apparent. That is, enhancing the overall quality of the parent-child relationship (i.e., the warmth and acceptance initially described by Eyberg, 2004) appeared to service an important protective factor. To address all of these objectives, four distinct levels of PCIT coaching were identified:

Level One Coaching: The most basic level of coaching, Level One coaching is designed to provide the parent with the words to say to their child and to structure the manner in which they communicate to their child. Level One coaching consists of the PCIT therapist/coach leading the parent by telling the parent exactly what to say (i.e., delivering a description, reflection, or praise). A Level One coaching prompt is typically followed by the parent repeating what the therapist/coach has stated (either verbatim or a close paraphrase), followed by the therapist/coach identifying the types of statement that the parent expressed. The basic process is described as the therapist/coach leading the parent, the parent reflecting what the therapist/coach stated, then the therapist/coach labeling and reinforcing the parent's statement through praise. Level One coaching can be used to develop and reinforce basic positive parenting statements by modeling a statement provided for/by the parent, such as:

C: (Child is playing with a toy truck, rolling it across the table) ''My truck is going into the garage'' (a block enclosure on the table which is simulating a garage).

T: (stated to the parent) ''Say, 'Your truck is rolling across the table and going into the garage.' ''

P: ''Your truck is rolling across the table and going into the garage.''

T: That was a reflection; great job! (Therapist/coach delivers a praise to the parent for an appropriate response.)

Level One coaching can also be used to provide a corrective response (i.e., a statement which is more likely to result in positive parenting) to the parent:

P: ''What do you want to play with?'' (In CDI, parent questions are discouraged, as they lead the play and often result in a command.)

T: ''There are lots of toys on the table for you to play with.''
P: ''You can play with anything on the table.''
T: ''Good job of changing the question into a statement.'' (Therapist praises parent for delivering an appropriate statement.)

Additionally, Level One coaching can intercept an inappropriate response by the parent and change it into a positive response:

C: ''These are my Legos. Don't touch them!''
P: ''Don't talk to me like that; give me some Legos so I can play with you.''

It is important for a PCIT therapist/coach to intercept this type of interaction, which may lead to negativity and child defiance. A Level One coaching prompt can be used to intercept such a potentially problematic statement, as follows:

C: ''These are my Legos. Don't touch them!''
T: ''You are playing with all the Legos.'' (description)
P: ''You're playing with all the Legos.''
T: ''That was a description, good job.'' (Therapist praises parent for delivering an appropriate statement.)

Lastly, a Level One coaching allows the parent to seek assistance from the therapist/coach when they just don't know how to respond or are unable to respond due to any emotional or stressful feeling that the child's behavior or statements are evoking in them. An example would be as follows:

C: ''I don't want to play with you. I like playing with Daddy.''
P: (Parent looks up into the mirror toward the therapist/coach.)
T: ''It sounds like you miss playing with Daddy.'' (This is a description, based on the parent's observation/listening to the child's statement.)
P: ''Daddy hasn't been able to be with us much lately, and you miss playing with him.''

Overall, Level One coaching prompts are designed to assist the parent to consistently make statements which are positive by modeling appropriate statements, providing guidance about statements, intercepting potentially problematic statements, providing a corrective action about a statement made by the parent, and/or reinforcing the parent for the positive parenting statement they provided. Finally, Level One coaching prompts also afford the therapist to provide repeated opportunities to praise the parent for engaging in desired behavior (e.g., CDI skills).

Level Two Coaching: In this second level of coaching, the parent provides the initial statement, followed by a responsive statement made by the therapist/coach, usually praise. Level Two coaching is typically used by parents who have acquired some basic understanding of the CDI skills (i.e., Praise, Reflection, Imitation, Description, and Enthusiasm) and are attempting to strategically make statements to obtain some specific child behaviors. Most simply, this would involve a parent initiating an appropriate CDI statement followed by a therapist/coach prompt (which is usually a praise for the parent's appropriate statement). A Level Two intervention would be:

P: ''Thank you for cleaning up the Legos.'' (Parent praises the desired behavior of child cleaning.)
T: ''Good job of keeping those praises going.'' (Therapist/coach praises parent for delivering an appropriate statement.)

In addition, a Level Two coaching prompt can support the parent for being more strategic in guiding the child's behaviors:

P: ''You're stacking the blocks carefully.''
P: ''And, you're really concentrating.''
T: ''Great job describing the behaviors that you want.''

Overall, Level Two coaching involves the parent initiating a positive parenting statement specifically designed to selectively and strategically apply the skills to obtain a desired child behavior followed by reinforcement (usually delivered in the form of a praise) by the therapist/coach. One of the benefits of Level Two coaching is that it provides ample opportunities to identify for the parent positive and praiseworthy behaviors exhibited by the child. When asked to initially describe their child's positive behaviors, many parents complain that their child does not exhibit any positive behaviors. Research examining high-risk parental attitudes and cognitions indicates that some parents repeatedly focus on negative child attributes/behaviors and fail to recognize many positive attributes/behaviors (see Milner, 2000, for a comprehensive discussion of social information processing and parenting). It is likely that the repeated identification of positive child behaviors alters the manner in which parents view their child, and subsequently enables them to link a positive child behavior with a positive evaluation of their child, which eventually contributes to their reevaluation of their child. Repeated positive affiliative statements linked specifically to the parent's appropriate statements (e.g., the parent states a praise to their child and receives an immediate praise from their therapist/coach for the praise they delivered) are likely to also transition to their incorporating these statements in their self-descriptions of parenting competence.

Level Three Coaching: In Level Three coaching, an important and substantive change occurs. Instead of simply attempting to provide parents with verbal skills to guide their child's behavior, Level Three coaching adds the component of delivering a rationale (or meaning) to the parent for the positive parenting skill statement. While training parents in developing the specific verbal skills to manage their child's behavior is essential, it is also important for them to understand the meaning and function of the specific skill statement (i.e., Why is it important to deliver a praise to your child when they are starting to clean up?). Ideally, the understanding of the rationale for each statement may increase its value to the parent, which then leads to better generalization to the complement of general parenting practices and strategies the parent possesses. Because there are many types of explanations for parent statements, the functions of Level Three coaching can be diverse. For example, a difficult skill for parents to acquire is to reduce questioning their child. While describing Level Three coaching, an example of providing a rationale for the concept would be as follows:

P: ''What do you want to play with?''
T: ''There are lots of toys on the table for you to play with.''
P: ''You can play with anything on the table.''
T: ''Good job; changing the question into a statement will allow your child to lead the play.''(Therapist praises parent for delivering an appropriate statement and provides the rationale for the skill.)

Another basic Level Three coaching prompt would be one that was supportive of the overall goals of PCIT (i.e., decrease child disruptive behavioral problems by providing positive endorsement for appropriate behavior), such as:

C: (While playing, the child allows some Legos to remain on the parent's side of the table.)

T: ''I wonder if you notice that he is sharing the toys with you.''
P: ''Thank you for sharing the toys with me.''
T: ''Great job praising those behaviors that you want to increase.''

In many situations the child behaves in an unacceptable manner during the treatment session. Another way to provide a basic Level Three coaching prompt that is supportive of the overall goals of PCIT (i.e., in this example, decreasing child disruptive behavioral problems) would be to prompt the use of strategic attention as follows:

C: (While playing, the child grabs all of the Legos and pulls them over to their side of the table.) ''These are my Legos; don't touch them!''
P: ''I'll play with something else.''
T: ''This would be a good time for you to use a 'when/then' statement.''
P: ''When you are ready to share the Legos with me, then I will play with you.''
T: ''You kept your tone nice and neutral with that description; good job. In this way you have removed yourself from the battle, and he will know that his sassy remarks result in you removing attention away from him rather than toward him.''

In addition, it is often important for a parent to have a clear understanding of the many common child developmental expectations related to *their specific child*. Level Three coaching can be used to provide a parent with a wide range of developmental information about a child. Some examples of delivering Level Three developmental expectation information include:

T: ''Bobby is at an age where he thinks everything belongs to him, including those Legos. We'll work on sharing a little later in treatment.''
T: ''Bobby is right on target with putting those big Legos together. Using smaller Legos may cause him frustration, because they require more advanced fine motor skills.''
T: ''Many younger children have difficulty correctly identifying colors. You can teach him the correct word by describing the color of the crayon and then praising him when he says it correctly.''
T: ''A child of Bobby's age should be able to help, at least a little, with cleaning up the toys. Push some toys in front of him so that he can help put a couple of toys in the box. Be ready to give him a big praise as soon as he starts to clean up.''

Lastly, a basic Level Three coaching prompt would assist the parent in generalizing the skill or concept to home and community. The example below continues with the clean-up scenario described above:

T: ''He's started to help; give Bobby a big praise.''
P: ''Thank you for helping me clean up the toys, Bobby.''
T: ''Perfect praising. You are allowing Bobby to be successful here in cleaning up, and so if you do that at home he will probably clean up more often.''

These three styles of coaching (levels one, two and three) with the parent are commonly taught and practiced through both components of PCIT, the relationship enhancement phase as well as the discipline phase. Under the guidance of the therapist/coach, the parent is prompted to be attuned to the child's behaviors, to reinforce appropriate behavior through positive attention, and to manage minor inappropriate behaviors through selective attention. An outcome of this process is that the relationship between the parent and child is enhanced, maladaptive behaviors of the child are reduced, parenting skills are improved, and parental stress related to the parent-child interrelationship is improved. Through the use of play as a medium, PCIT provides an environment where the parent can learn, practice, and gain mastery of skills that focus on safe and effective communication. And within this safe and nurturing environment it can be expected that children will begin to explore and express their feelings, thoughts, experiences, and behaviors. This leads to Level Four coaching.

Level Four Coaching: In the last level of coaching, the therapist/coach suggests ways in which the parent can change the child's perception of the world and/or reframes the child's experiences of the past to fit into the child's current or past experience, placement, and/or relationships. It is during this level that the therapist can address issues that (a) may be concerning to the child, (b) may require greater understanding on the part of the child, (c) may need the parent to provide some type of support, and/or (d) may enhance the child's perception of the parent as a supportive and concerned caregiver. The primary focus of Level Four coaching is to shift the child's perception of themselves, their parent, and/or relationships with others. For example, some children from impoverished early childhood environments often have difficulty sharing with others and relating positively to others.

C: ''These are my Legos. Don't touch them!''
T: (Stated to parent) ''You don't want me to touch your Legos.''
P: ''You don't want me to touch your things.''

Other possible Level Four coaching prompts include:

T: ''Thank you for telling me what you want, now I can help you better.''
T: ''When you use words, then I can understand better what you want.''
T: ''Explaining to me what you want is better than yelling at me.''
T: ''I understand that right now you want to have your own special things.''
T: ''I won't touch your things until you want me to.''
T: ''It's my job as your mother to make sure you and your things are safe.''

Sometimes, the child incorporates concerns or perceptions of the world that reflect past traumatic experiences. These types of statements or behaviors, which are often brought into the treatment room by the child, can be addressed through Level Four coaching also. (Some traditional play therapists may identify this as trauma work.) For example, a child exposed to domestic violence and fearful of an aggressive stepfather may make statements or depict play scenarios related to his/her concerns:

C: (While playing with a dollhouse, the child appears anxious while playing with a small male figure) ''And this is the daddy, and he's banging real hard on the door!''
T: (Stated to the parent) ''It looks like you have scary feelings about Daddy coming to the door.''
P: ''You have feelings about Daddy coming back home.''
C: ''Yeah, we have to hide!''

Further possible Level Four coaching prompts could include:

T: ''I will make sure that you are safe.''
T: ''If Daddy comes back, we'll leave quickly.''
T: ''I will call the police to make sure we are safe.''

Often, Level Four coaching requires a discussion with the parent about their abilities and plans before addressing the issue/concern

> within the context of a treatment session. Sometimes this may be the development of a plan in which the parent can address the issue/concern outside of the treatment session or simply a discussion of an approach that is most comfortable for the parent. With Level Four coaching, many more traditional play therapists begin to see comparisons to the interpretive process that occurs during an individual play therapy session with a child. This should not be construed as a novel approach since filial therapy, in diverse forms, has been a part of play therapy approaches for several decades (Bratton, Ray, Rhine, & Jones, 2005; Watts & Broaddus, 2002). As previously emphasized, a definitional component of play therapy—the use of play as a medium—is central to PCIT. Throughout the course of PCIT, the selection of toys and the timing of introducing a specific toy may impact the therapeutic process. Children referred to PCIT are typically reported to have maladaptive, negative attention-seeking behaviors. Parents generally report a high degree of parental stress related to the parent-child relationship due to time and energy spent on managing disruptive behaviors. Therefore the first component of PCIT emphasizes enhancing the relationship between the parent and child. Toys that would encourage rough play, cause harm to self and/or others, require limit setting, or have preset rules are not offered within the PCIT playroom setting. Rather, creative and instructional toys are endorsed (e.g., building blocks, Legos, Mr. Potato Head, tea set). As presented, through levels one, two, and three coaching, a parent learns and demonstrates mastery of positive communication skills (i.e., Praise, Reflection, Imitation, Description, and Enthusiasm). Level Four coaching usually occurs when toys that encourage feelings, thoughts, and experiences are introduced into the PCIT play session (e.g., playhouse, dolls, schoolhouse, miniature people, and dangerous-looking plastic animals). For play therapy to be successful between the parent and child it is essential that the parent provide a safe and nurturing atmosphere for the child to express him/herself. The therapeutic expertise is in knowing when the parent is ready to receive and understand the child's expression and exploration of their feelings, thoughts, and experiences (through toys as a play medium).

There are several important considerations to understand about levels of coaching. First, levels of coaching provide different functions, all of which are important within the context of a specific parent-child interaction. They should not be viewed as hierarchical, or as being of greater or lesser value than another level of coaching (e.g., Level Four coaching is not an objective, nor is Level Four coaching better then levels 1–3). It is likely that throughout the course of PCIT, coaching will fluctuate through levels 1–4, with levels one and two occurring more frequently during the initial phase of treatment (although they continue throughout the course of treatment), and levels 3–4 occurring during later phases of treatment (and tend to occur infrequently during the initial phases of treatment, when the focus of treatment is on developing basic parent skills). Some parents, due to emotional and/or intellectual limitations, may not easily understand Level Three and Four coaching prompts, suggesting that this level of coaching may not be appropriate. Finally, Level Four coaching also requires the parent to understand the situation (e.g., concern, fear, anxiety) that the child raises and be prepared to respond. Because of this, extensive discussion will need to occur between the therapist/coach and the parent prior to directly addressing the child's concern through a Level Four prompt.

SUMMARY

In summary, PCIT is an effective and well-researched intervention not commonly associated as a form of play therapy. However, closer examination of the origins of PCIT, the theoretical frameworks thought to underlie the changes in parent-child relationships and development and functioning of PCIT during the last three decades, all bring to light its value as one of the most effective tools available today for improving parenting skills, decreasing child behavioral problems, and enhancing the quality (i.e., warmth and acceptance) in parent-child relationships. More recently, the development of levels of coaching has highlighted a mechanism to address more discreetly many of the issues that Hembree-Kigin and McNeil (1995) discuss when they describe ''behavioral play therapy skills'' (p. 11). Levels of coaching provides a means for therapists to train parents to acquire both the skills to manage their child and to enhance parent's understanding of their child's developmental status and acquire appropriate developmental expectations, and support the child's feeling of security and support within the context of their relationship with the parent. While it is easy to see that a behaviorally based intervention such as PCIT changes patterns of behavior in the parent and child, it is important to note that there are also important shifts in cognitions and attributions. Developments in PCIT, combined with levels of coaching, serve to strengthen parent-child relationships, leading to a form of attachment therapy that is the most effective intervention in supporting healthy relationships.

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CHAPTER 11

Primary Project

Fifty Years of Facilitating School Adjustment

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INTRODUCTION

''Do you want to know something?'' Ronald asked. ''Sure,'' replied Andrea. Ronald looked at her warmly and stated, ''You know I used to not like school, but ever since I met you, I like being at school.'' We frequently hear stories like this one from child associates such as Andrea in our travels to Primary Project sites across the country. From the child who was at first afraid to come to the playroom but worked through that fear, to the child who wished that his child associate didn't own a watch so she wouldn't know when the session was over. One child associate recently reported that she had a chance meeting in a local department store with a child whom she saw years before in Primary Project. The child, now 12 years old, threw his arms around her with true joy when he saw her. The child associate said afterward, ''I know the simple act of being truly present with and caring for this child touched him deeply and has affected how he sees himself. I feel honored and grateful to be part of that.'' These stories and others like it are the essence of Primary Project.

Primary Project was piloted in 1957 as a joint venture between the University of Rochester and the Rochester City School District. The initial iteration was prompted by two real-world concerns: (a) classroom teachers spent 40 to 60 percent of their time dealing with the two to four children experiencing difficulties in the classroom and (b) the sharp rise in mental health referrals for children transitioning from elementary school to the higher grades (Cowen & Hightower, 1989). These concerns are as real for us now as they were in 1957.

We continue to hear from teachers about how a small number of children can cause complete disruption in a classroom. Further, adjustment difficulties faced by today’s youth are not new. In 1969, the Joint Commission on the Mental Health of Children reported that a significant number of American schoolchildren experienced school adjustment problems. Throughout the years, as Adelman and Taylor (1998) point out, schools across the nation have attempted to offer several programs that help to prevent or reduce psychosocial and behavioral difficulties that children face. Current data show that almost “21 percent of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment” (U.S. Department of Health and Human Services, 1999, p. 123).

While we have seen 50 years pass since the initial pilot, Primary Project continues to help children in prekindergarten through third grade become better adjusted to the school experience. Currently, Primary Project is being implemented in more than 2,100 schools nationwide. Programs, which often operate under various names such as Special Friends and Primary School Adjustment Project, can be found in Arkansas, California, Connecticut, Delaware, Florida, Hawaii, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, Texas, and Washington.

PRIMARY PROJECT

A child’s early experiences in school are critically important for several reasons. The entrance to school marks a period of significant biological, developmental, familial, social, and situational changes for young children (Perry & Weinstein, 1998). Kindergarten requires children to adjust to academic challenges, new social interactions, and a demand to self-regulate emotions and behavior (Grolnick, Kurowski, & Gurland, 1999). Although many children progress through school without difficulty, there are a considerable number of young children who experience school adjustment as a challenge (Entwisle & Hayduk, 1982; Perry & Weinstein, 1998).

Young children who experience difficulties adjusting to the structure and rigors of formal education may be at a disadvantage throughout their academic careers. Many later adjustment problems often emerge during one’s first or second year of school (Alexander & Entwisle, 1988). Perry and Weinstein (1998) provide a literature review that concludes that early learning and behavior problems correlate with more serious difficulties later in life, such as academic failure, behavior disorders, and school dropout.

Primary Project, a school-based early detection and prevention program, enhances social, emotional, behavioral, and learning skills and reduces social, emotional, and school adjustment difficulties in preschool through third-grade children. Initially, young children with early school adjustment difficulties (e.g., mild aggression, withdrawal, and learning difficulties) are identified through the use of carefully developed screening and detection methods. Once at-risk children are identified, these children meet with carefully selected and trained paraprofessionals (child associates) who utilize developmentally appropriate child-led play as a vehicle to provide them with timely, effective support. Child associates work closely with and under the supervision of mental health professionals to provide effective and cost-efficient care for the children they serve. Evaluation studies show that Primary Project helps children become more productive in school (Cowen, Hightower, Pedro-Carroll, Work, & Wyman, 1996; Nafpaktitis & Perlmutter, 1998).

EVIDENCED-BASED TREATMENT

It is no secret that we are living in an age where accountability and measurable outcomes are paramount in health services and educational settings. Private funders, government funders, school administrators, and program developers are among the many of those who are sensitive to the need for providing evidence for the effectiveness of interventions designed to help children. Primary Project is no exception.

Research on Primary Project started when Primary Project started; it has been a continuing, essential part of the program's fabric ever since. Tests of Primary Project's effectiveness as a prevention program have utilized several evaluation designs. Each of these evaluation designs has strengths (methodological or ecological) that provide complementary evidence about program efficacy (Cowen et al., 1996), including a composite evaluation for seven consecutive annual cohorts (Weissberg, Cowen, Lotyczewski, & Gestin, 1983). Primary Project's research effort has considered process variables as well as outcome variables. For example, Primary Project's research has shed light on specific program elements that improve practice as well as deepen our understanding of factors that affect the relationships between child associates and children and child associates and their supervisors (Cowen & Hightower, 1989; Cowen et al., 1996).

Several studies have used control groups designed to evaluate the effectiveness of Primary Project. In one such study, approximately 600 children from 18 school sites were randomly assigned into immediate intervention and delayed treatment groups. Using standard comparison techniques for this design, children who received Primary Project services, relative to those awaiting services, showed significant decreases in adjustment problems, such as lower aggression, fewer learning problems, and increased social-emotional competencies (e.g., frustration tolerance, peer relations) (Duerr, 1993). Another evaluation of the Primary Project model also utilized a wait-control design and employed a three-month follow-up evaluation (Nafpaktitis & Perlmutter, 1998). In this study, children in an immediate intervention group, compared to wait-list controls, declined in teacher ratings of learning problems and shy-anxious behaviors, and increased in task orientation and peer social skills. Improvements in both problems and competencies placed children within a range of functioning exhibited by nonreferred peers. At a three-month follow-up, children had not significantly decreased in functioning based on teacher ratings (Nafpaktitis & Perlmutter, 1998).

Several evaluation studies have compared adjustment between children receiving Primary Project services and comparably at-risk children in schools without Primary Project services. This design allows careful matching of intervention and comparison groups and tracking of their adjustment over time (Cowen et al., 1996). One such study compared (a) children in the Primary Project model who received an average of 25 40-minute contacts over a five- to six-month period, and (b) comparison children with similar initial adjustment status identified in non-Primary Project schools. In this study, children served by Primary Project were shown, after a school year, to decrease in adjustment problems and increase in adaptive competencies compared to comparison children (Winer-Elkin, Weissberg, & Cowen, 1988). Chandler, Weissberg, Cowen, and Guare (1984) evaluated 61 urban children, seen two to five years earlier in the Primary Project model, with 61 matched to the Primary Project sample by gender, grade level, and current teacher. Adjustment ratings by children's current classroom teachers confirmed that children seen in the Primary Project model had, two to five years later, maintained their initial adjustment gains.

There is consensus among experts that Primary Project is an exemplary program based on the evidence available from decades of evaluation and research on Primary Project. In 1984, the National Mental Health Association awarded Primary Project the Lela Rowland Prevention Award as the outstanding prevention program (Cowen & Hightower, 1989). Four years later, in 1988, Primary Project was reviewed by the New York State Education Department using national research-based criteria and was the first program designated a validated program under New York State's Sharing Successful Programs using those research criteria. Primary Project was awarded the ''Model Program in Service Delivery in Child and Family Mental Health'' in 1993 by the Section of Clinical and Child Psychology Section I of Clinical Psychology Division of Child Youth and Family Services of the American Psychological Association. The United Way of Greater Rochester awarded Primary Project the ''1995 Quality Award for Excellence in Human Service Programming,'' which was based on an independent review of program processes and documented outcomes.

Primary Project has also been highlighted by the National Registry of Evidence-based Programs and Practice (NREPP), a service of the Substance Abuse and Mental Health Services Administration (SAMHSA). The National Registry of Evidence-Based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The registry can be accessed at http://www.nrepp.samhsa.gov.

According to Cerio and Boehm-Morelli (1999), methodological difficulties surrounding play therapy research include the absence of control and comparison groups. Suggestions for the research include the use of wait lists, baseline data, and incorporating the use of alternative interventions into the design. Measurement problems include the use of inconsistent, nonstandardized assessments. Further, philosophical and ''conceptual biases run rampant in play therapy research'' thus treatment infidelity creates even more problems as it has been difficult to establish whether or not a particular model is responsible for the success of the client (p. 84). The accolades that Primary Project has received in combination with the program's rich research history are highly significant for several reasons. Primary Project is a child-led play-based approach that has been studied using experimental, and quasi-experimental methodology. The NREPP review of Primary Project research further demonstrates and publicizes that there is empirical evidence for play-based approaches to helping children become better socially and emotionally adjusted. Moreover, the NREPP review is significant because it has taken into account the need to bridge empiricism with practicality and demonstrates that it is important for practitioners to be able to utilize treatments that have scientific backing and also fit the needs of the real world. Beyond the review of outcomes, NREPP also provides information on Primary Project's ability to be disseminated to a large audience of consumers.

THE ROLE OF PLAY IN PRIMARY PROJECT

Before fully discussing the role that play has in Primary Project, it should be made clear that Primary Project is not considered therapy or more specifically play therapy. First, child associates are paraprofessionals and not masters-level play therapists. They are well-trained individuals with a passion for helping children and a natural ability to be empathic, accepting, and nonjudgmental. Child associates undergo intensive two-day training on the key components of Primary Project and spend a considerable amount of time learning how to conduct child-led play sessions. In addition, they receive weekly supervision from the mental health professionals in their schools or agencies. The role of the child associate, their training, and supervision will be discussed in more detail later in this chapter.

Second, Primary Project is a targeted prevention program that helps children with mild school adjustment difficulties become better adjusted to the school experience. While play therapists often deal with more severe cases or children with diagnosable conditions, child associates most oftentimes do not. Careful steps are taken during the screening process to ensure that children fall within the mild adjustment problem range and that they are suitable for interaction with a child associate. This is important so that child associates are not expected to work beyond the scope of their training. While psychotherapy or play therapy may be appropriate to serve as the sole line of defense against a child's emotional difficulties, Primary Project is not designed as a stand-alone treatment but rather it is intended as a support for children who need extra attention or a more focused adult relationship during the school day. A more detailed description of the screening process will be presented later in this chapter.

Primary Project is, however, a play-based approach. While it is not play therapy per se, theoretical principles from the play therapy literature are often borrowed to conceptualize the intervention. Most importantly, Primary Project is a relationship-based approach where the relationship that develops between the child associate and the child is thought to be highly curative. Within the context of a Primary Project playroom, children can develop a meaningful, personal, and individual relationship with a caring adult. The toys become a way for children to express themselves in a developmentally appropriate way that does not rely on words or conversation. Child associates understand a child's play and most importantly understand how to be empathic and sensitive to the communication that flows from that play.

Play is an inherent part of children's lives. For example, children may engage in expressive play in order to cope with the demands and pressures of an adult world. Thus, play not only serves as a fundamental childhood activity but can also serve as a therapeutic outlet for children's emotions. Hartley, Frank, and Goldenson (1952) suggested that the therapeutic effects of play are of equal importance and value for both well-adjusted children and those experiencing personal difficulty. As Schaefer (1993) points out, play not only supports normal development but can also help improve behavior.

Now in the twenty-first century, common perceptions are that children spend more time on solitary play, electronic play, and competitive and structured sports. Afternoons and Saturdays of unstructured or free play seem few and far between. As the opportunities become less available, the need for this type of play increases. The recent report from the American Academy of Pediatrics (Ginsburg & the Committee on Communications & the Committee on Psychosocial Aspects of Child and Family Health, 2007) contends that children have less time for unstructured free play in schools and in their lives away from schools. Further, this report suggests that ''some children are given less time for free exploratory play as they are hurried to adapt into adult roles and prepare for their future at earlier ages'' (p. 184).

In Primary Project, child-directed play serves many functions. This type of play is seen as the primary vehicle for establishing a strong working alliance between the child associate and the child. Play also allows for self-expression as preschool through third-grade children have relatively limited ability to verbalize their thoughts and feelings or to use abstract verbal reasoning. Finally, play serves as a conduit for skill-building and competency enrichment. These functions of play are highly intermingled throughout the intervention, and the trained child associate is knowledgeable about how these functions of play help facilitate a child's school adjustment. For example, a child is allowed to choose what to play with in a Primary Project playroom. Play is not viewed as a way to engage in the child associate's agenda or satisfy a teacher's demand to fix the child. Child-directed play is used because it allows the child to play out the difficult emotions, concerns, or worries that are important to them. It is through play that the child can be fully expressive and tap into the most salient difficulties facing him or her. Some children use the play experience in Primary Project as a way to feel more competent and successful, often creating play situations where they can gain mastery of situations that may be challenging. Others may use role-play and fantasy play to deal with stressful experiences and strong feelings. Although each child's play can be different, common elements include the use of fantasy, creativity, and imagination.

The Theoretical Approach to Using Play in Primary Project

Primary Project borrows from the theoretical and philosophical underpinnings of child-centered play therapy. In line with Axline's (1947, 1969) eight principles of play therapy, the child associate builds rapport with and accepts the child as she is, establishes a sense of permissiveness in the playroom, maintains respect for the child, reflects feelings, sets limits when necessary, lets the child lead the way, and does not hurry the child's growth. This child-centered way of being allows the child to choose activities in the playroom and develop an increased sense of autonomy, self-direction, and self-competence.

Rogers' (1951, 1957) core conditions are also at the heart of the Primary Project intervention. While play provides a common ground for building a connection, the child associate's use of empathy, genuineness, and unconditional positive regard strengthens the bond and aids the child associate in personifying Axline's principles.

CURATIVE FACTORS OF PLAY

Clinicians and researchers have sought to identify the specific elements inherent in play that make for therapeutic change. A comprehensive listing of the 14 therapeutic factors of play is presented by Schaefer (1993). Primary Project addresses many of these therapeutic factors.

First and foremost are the therapeutic factors of relationship enhancement and overcoming resistance. Play serves as the primary vehicle for establishing a strong working relationship between the child associate and the child. Child associates work to form a consistent and safe relationship with a child in order to overcome a child's resistance and support rapport building. Children tend to like adults who are playful and enjoy the world of play. When an adult at school is willing to play with a child, the child typically engages more easily, lowers any defenses, and begins to build a nonthreatening relationship.

This relationship at school also touches on another curative factor: attachment formation. While we often think of this kind of attachment as attachment to primary caregivers, in Primary Project we contend that the special play-based relationship helps the child feel more attached to school. When children feel that school is a safe place where they are valued and accepted by both adults and peers, they seem to engage more readily in both the academic and the social aspects of the school day.

Some children use the play experience as a way to feel more competent and successful, often creating play spaces where they can gain mastery of situations that may be challenging. It is through play that the child can be fully expressive and tap into the most salient difficulties facing him or her. Others may use role-play and fantasy play to deal with stressful experiences and strong feelings. Whether it is to master developmental fears or to relive or reprocess traumatic events, play has many therapeutic powers.

With the relationship in place and a child's deep sense of safety in the play room, the Primary Project child associate can concentrate on recognizing and valuing the child's feelings, responding empathetically, and accepting the total child.

The Primary Project child-led play intervention also serves as a mechanism for skill-building and competency enhancement. In Primary Project, much like in child-centered play therapy, all of the child's feelings are accepted but not all behaviors. Consistent limits are set around property destruction, self-harm, child-associate harm, removal of the items from the playroom, and general safety concerns. Consistent limit-setting provides structure for the child and allows them to experience real-time and realistic consequences for their actions. One way this is accomplished is by using Landreth's (2002) ACT model for limit setting, whereby the child associate acknowledges the child's want or desire, sets a firm limit, and targets an alternative behavior. Different than directive approaches that teach children more specific skills, limit setting in a child-directed session allows the child to internally experience feelings surrounding a limit and provides them with the ability to make choices about their behavior.

THE PRIMARY PROJECT PLAYROOM

Primary Project playrooms look very different from the classrooms that fill a school building. As academic standards seem to be pushing play to the periphery of our classroom walls, it is rare to see expressive play in the classrooms. Therefore, coming to the Primary Project playroom is almost always a treat for young children.

The space for the playroom is set aside by the school administration, and ideally the space would be located near the grades that will most frequently be a part of Primary Project. The physical spaces that are utilized for Primary Project are most often unused classrooms, therefore special room requirements are not necessary. Sometimes these spaces have running water and attached bathrooms, but it is not required. Moreover, the space need not be extraordinarily large. What is important is that it offers enough room for the child associate and the child to be comfortable during play. A 10-foot × 15-foot or 15-foot × 20-foot room should suffice.

Similar to most child-centered play therapy rooms, the setup of a Primary Project playroom is simple. There is often a selection of real-life toys, aggressive toys, scary toys, nurturing toys, and manipulative toys. Real-life toys to promote fantasy play, such as dress up, phones, cash registers, doctor or veterinarian kits, and police cars, are encouraged.

Building blocks, Legos, Lincoln logs, or other manipulative-type toys help a child to problem solve and gain mastery. If space permits, more active toys like Nerf balls and bats or a basketball hoop may be included. Toys that are both scary and aggressive, such as dinosaurs, monsters, lions, alligators are also found to remind children that the space is a place for all feelings, including the uncomfortable feelings which can be played out. Nurturing toys such as baby dolls allow for children to express feelings of caring for others while also helping to elicit thoughts and feelings about familial relationships. A range of expressive art media, (clay, paper, markers, paints) and sand or water trays may also be available.

Both old and new toys are incorporated in order to help children feel comfortable to explore the room and engage with the materials. Toys selected for the playroom should represent diverse populations, be relatively gender neutral, and characterize a range of family types and socioeconomic status levels.

Since school adjustment is of importance, school-related play materials, such as a school bus, chalkboards, and miniature schools, are also available and accessible to the children. Different than the private practice or agency office, particular toys may not be available due to school policies. For example, most school districts have very strict weapon policies. Weapons, including toy weapons, would not be placed in a Primary Project playroom. If children have the need or desire to play aggressively they will find a way to play out their aggression with other less literal representations and within the safety of the playroom. This is less confusing to the young child and respects the school district's policies.

CORE COMPONENTS OF PRIMARY PROJECT

Primary Project is based on six core components, each of which is essential to the program's success. These key structural components allow for adaptation to the local district/sites, while retaining the flexibility to meet the uniqueness of the individual setting. This makes Primary Project applicable to a broad range of children and communities. The core components are:

- focus on young children
- early screening and selection
- use of paraprofessionals, called child associates, to provide direct services to children
- role change of the school-based mental health professional to supervisor

- ongoing program evaluation
- integration into the school community

The following sections will discuss five of the six core components with the exclusion of *ongoing program evaluation* because this was discussed in detail earlier in the chapter through our review of Primary Project research.

Focus on Young Children

Because the aim of Primary Project is to prevent school adjustment difficulties that can impact the course of a child's academic career, it is logical to focus the delivery of services to young children in preschool through third grade. Raver and Knitzer (2002) reported that ''more than 32% of all young children are affected by one risk factor such as low income, low maternal education, or single-parent status'' (p. 3). In a report from the U.S. Department of Education, National Center for Educational Statistics (2001), it was stated that children from single- and multiple-risk families display increased fighting with classmates, increased feelings of anger, and argue more often when compared to children from homes with low or no risks present. Further, this report also stated those children from single- and multiple-risk homes are less proficient in reading and mathematics. Taken together this information sheds light on potential difficulties children face when adjusting to the school environment, especially for those children entering school for the first time. Between the small groups of children who are experiencing severe difficulties and those children who are well adjusted to school lies a significant number of children who experience mild school adjustment difficulties. For these children, speaking up in class, making friends, or focusing on the task at hand may be challenging. These children may not need outside therapy or special services, but they oftentimes need an anchor or a connection with an adult in the school. These mild difficulties, if supported with an intervention in the early grades as part of the continuum of care, can be extinguished before they begin to stabilize in the later grades.

Early Screening and Selection

The early screening of all children in targeted grades and the selection of children who are appropriate for Primary Project is the cornerstone of this program. When new programs begin, we suggest that a school choose one or two grades to focus on. For example, a new program might choose to concentrate on servicing kindergartners and first graders rather than attempting to service the full K–3 grade spectrum. This allows a new school to build the program slowly and take careful measures to avoid being overwhelmed by accepting responsibility for all primary grade children.

In new Primary Project training, we often describe the screening process using the metaphor of going to the dentist's office. Take a moment to think about your last trip to the dentist's office for a checkup. Perhaps the hygienist brought you in, took some x-rays, gave a cursory glance at all your teeth, investigated each tooth separately, cleaned each tooth, polished each tooth, and then called the dentist in to check you out as well. The dentist then goes through the process of checking your complete set of teeth followed by a closer look at teeth that need special attention. In Primary Project, we choose to first look at all the children in a classroom much like the hygienist looks at all your teeth. The screening of a complete classroom can be done in several ways. We suggest the use of a standardized screening tool. A common tool used by programs nationwide is the *Acting Out, Moody, Learning-Revised* behavior rating scale (AML-R). The AML-R is a brief screening tool designed primarily for teachers to use in identifying children experiencing school adjustment difficulties. The AML-R is a 12-item measure that assesses a child's acting out behavior, his or her moodiness or shy-anxious behavior, as well as learning difficulties that the child may have. It is simple to use and usually takes about 15 minutes to complete for each child.

The completion of the AML-R is only one piece of the Primary Project screening process. Entry into Primary Project should never be based solely on results from the AML-R. In addition, screening may also include a review of a child's cumulative record, observations of classrooms by the school mental health professional or child associate, discussions with parents, and child self-report. The central message conveyed to new programs is that data on groups of children should be collected from many sources and that a child's functioning or school adjustment cannot accurately be assessed from only one vantage point or only during one moment in time.

Once screening data has been collected and the AML-Rs have been scored, conferences are arranged to discuss each child screened during the process. Conference participants usually include but are not limited to grade-level teachers, child associates, the supervising school mental health professional, parents, and administrators. The flexibility of the Primary Project program allows each school to decide who should be at the conference based on the roles and responsibilities of faculty and staff and the needs of the school. Conferences, as a general course, are half-day to day-long meetings in which the selection team reviews the data collected on each child individually, discusses the appropriateness of the child's placement in Primary Project, brainstorms alternative services that might be more appropriate, and concludes with a final decision about whether or not to enroll the child in the project.

Before a child can receive Primary Project services, parents/caregivers must sign a consent form allowing their child to participate. We suggest that permission be obtained by the individual who has the best relationship with the child's parent or caregiver. In many schools, the child's teacher is the person who usually sends the permission form home or makes initial contact with the parent about permission. It is often the case that the supervising school mental health professional follows up with parents when permission is not given or the form does not return to school. This allows the school mental health professional the opportunity to answer any questions about the service.

Use of the Paraprofessional in a Direct Service Role

The paraprofessionals, often called child associates, who provide direct services to children are the heart of Primary Project. They are selected for their warmth, interest, and ability to form trusting relationships. Their main responsibility is to listen, attend, and work with children identified for participation in Primary Project. Child associates also form working relationships with the supervising school mental health professionals and communicate with parents and teachers at the discretion of, and under the direction of, their program supervisors. Although selection of child associates is based on their strong interpersonal qualities, life experiences, and help-giving potential, ongoing training and supervision is essential for them to work effectively with young children.

Child associates must have the ability to communicate effectively with children, other child associates, teachers, and school staff. The ability to do this depends on their interpersonal and experiential qualities rather than on advanced educational degrees.

Those hired to be child associates should enjoy working and playing with children, be motivated, be interested in program goals, have a positive attitude toward school, have the ability to understand and work with culturally diverse groups of children, have good organizational skills, and have the ability to work interdependently. Child associates do not have to be first responders to crisis situations, which falls within the multifaceted role of the school mental health professional. Some expectations of child associates may include establishing trusting relationships with the children, participating in conferences related to the children in Primary Project, participating in training, and distributing, collecting, and scoring screening and assessment measures under the supervision of the mental health professional.

Role Change of the School-Based Mental Health Professional to Supervisor

Central to the success of Primary Project is the strong working relationship between the school-based mental health supervisor and the child associate. Allowing the child associate to focus on the children in need of prevention services frees up the supervisor to see children with more severe difficulties. The result is that supervision of the child associate requires much less time commitment than personally seeing the total number of students with mild adjustment difficulties. Thus, supervisors geometrically expand their role and impact in the school setting.

As the challenges that children present are ever changing, supervisors offer support, education, and knowledge to the child associate. They are also the key professional to identify and recognize if a child may need more intensive services than Primary Project is intended to provide. In order to do this, Primary Project training for supervisors has been highly emphasized in recent years. As part of program development and professional development, districts are encouraged to schedule supervision workshops and trainings for all mental health professionals supervising Primary Project. Further, we continue to encourage supervisors to attend the same trainings as child associates in order to fully understand each other's roles and responsibilities.

Another role of the school-based mental health professional in Primary Project is that of trainer. Supervisors are often responsible for conducting training and informational workshops for school staff, funders, and parents. Curriculum for training on the play intervention, the link between social and emotional competence and academic success, and basic helping, skills to name a few can be obtained through the Children's Institute. Customized training to meet the unique demands of a team can also be accommodated.

Integration into the School Community

Over the years it became clear to us that Primary Project Programs that are embedded into the fabric of the school system are the most successful ones.

What do we mean by being integrated into the school community? One district in western New York, for example, includes a write-up about Primary Project in both the school newsletter and the district newsletter. In many schools across the nation, teachers are provided with yearly Primary Project orientations to help new and veteran teachers remember the dual importance of social and emotional competence and its relationship to learning. Primary Project was never meant to be a stand-alone program. It is part of the continuum of services available to children, families, and teachers that support learning. Data collected on Primary Project indicates that children who feel positive about the school experience and the relationships at school may be better equipped to take advantage of learning opportunities.

Schools implementing Primary Project with fidelity meet the national Primary Project standards. The standards were developed by a national panel of Primary Project staff in order to ensure that the thousands of programs across the country were represented. Programs adhering to the national standards can apply for national certification. National certification involves a half-day visit to a school site by an objective, trained program reviewer who assesses the program's adherence to the national standards. Each year, the number of schools applying and meeting the standards continues to grow.

CONCLUSION

For more than 50 years, Primary Project has helped children become better adjusted to the school environment. Its longevity is due in part to a strong and continuous research agenda and the implementation of rigorous standards of quality. Further, the program is successful because of its ability to be flexible and meet the unique needs and culture of individual school sites. Those involved with Primary Project are strong advocates for a child's right to play, especially in an age where play is becoming perceived as less important in educational settings.

Now more than ever, as the demands of schools increase and children grow up in an ever-changing and complex world, programs such as Primary Project are vital. Recognizing the simplicity of what children need is at the heart of this program. Children need adults both at home and school to have time for them. They need adults to be interested in their world. They need adults to honor and understand play as one of the most powerful forms of learning and communication Above all, children need relationships with safe, inviting, and emotionally responsive adults who value them without judgment.

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SECTION IV

POSITIVE-OUTCOME EMPIRICALLY BASED PLAY THERAPY TREATMENTS

THIS SECTION HIGHLIGHTS four play therapy treatments that have shown positive outcomes. Two chapters deal with approaches that address child-parent relationships, another looks at using an Adlerian-based model to enhance teacher-student relationships, and the fourth covers the use of sandtray therapy. Each chapter brings in ways that cognitive behavioral therapy components can be integrated into these more traditional play-based treatments. My thinking in including these chapters was to help both cognitive behavioral and play therapy clinicians see how play therapy can be understood in CBT terms and adapted to combine CBT features. In addition, while play therapy research lags behind that of CBT in showing treatment efficacy at the evidence-based level, the four treatments presented in this chapter show promise for the future.

This section begins with Alicia Lieberman and Lisa Inman illustrating the use of play in child-parent psychotherapy as a vehicle for increasing parental understanding of their child's inner experience and promoting reciprocity and pleasure in their interactions.

This multitheoretical treatment approach is used with children from birth to age five in order to enhance or restore the child's mental health through improvement in the parent-child relationship. Much like PCIT in Section III, CPP consists of joint sessions with child and parent, with play utilized as a primary therapeutic modality to encourage developmentally appropriate interactions and to guide the parent's understanding of the meaning behind their child's play. A case study is presented whereby the reader can see the treatment process unfold as well as read the therapist's responses. The therapist enters the child's play when needed to explain, educate, interpret, and reframe to increase the parent's understanding and for the child to begin to understand their parent.

Filial therapy, highlighted by Risë VanFleet in Chapter 13, is another way of increasing parent-child interaction yet utilizes a different approach. Bernard and Louise Guerney developed this approach in the late 1950s as a theoretically integrative model. More than 40 years of research has been conducted using this approach. Unlike the first chapter in this section, filial therapy is a form of family therapy in which the therapist models, trains, and supervises parents as they learn to conduct nondirective play sessions with their own children. As the parent's competence and confidence in conducting the weekly play sessions grow, the parents transfer their play sessions to home. The therapist continues to monitor the interactions and sessions to help the parent generalize their skills and interactions for use in daily life.

The special parent-child sessions can continue independently after discharge and can continue to help enrich the family relationship and prevent future difficulties. Filial therapy is used with children aged 2 to 12, with adaptations for use with older children. It can also be conducted in groups or with individual families and for a variety of relational difficulties. The author points out the strong elements of both play therapy and cognitive behavioral therapy and helps to translate the treatment approach using both frameworks. A case study is included that offers the reader a clearer picture of how the various components are implemented.

Kinder Training shows similarity to this section's first two chapters in that its focus is on relationship enhancement. However, the teacher within the classroom is utilized as the change agent. It is an effective teacher consultation model based on developmentally appropriate strategies for making positive connections between teachers and students. JoAnna White and Lauren Stern Wynne present how child-centered skills from an Adlerian theoretical approach are utilized. Teachers are trained to use play in the classroom via modeling and coaching provided each week as the teachers practice. Tracking, empathy, encouragement, and limit setting are the core skills taught the teachers, similar to the Filial Therapy training of parents in the last chapter. Kinder Training is a method of consultation that empowers educators to connect with their students, which encourages their personal development and academic achievement. Educators find that how they conceptualize their student's changes, and that they are able to learn and use communication skills results in enhancement of their relationship with their students. Within the shift in thinking and subsequently the shift in the relationship, the student begins to view themselves differently, feeling encouraged and connected.

This section closes with Chapter 15 by Daniel Sweeney and Linda Homeyer on sandtray therapy. Sandtray therapy is an expressive therapy that has a lot of flexibility in being able to move from a nondirective to directive approach or from being fully nonverbal and projective to being cognitive and solution focused. It allows for the unfolding and processing of intra- and interpersonal issues using a tray or a container, for sand, along with a collection of miniatures. These miniatures represent symbols and images that the child or adolescent can use to represent their words and that become a means of communicating in the therapy. The client does not need to directly verbalize painful issues. The authors outline the theoretical background, coming from the work of Margaret Lowenfeld, as well as that of Dora Kalff, who was a Jungian-trained therapist, among others in the field of sandtray therapy. They outline the various components of the process and benefits of its use. The chapter contains descriptions of the tray, which miniatures to have on hand, and the various stages of the treatment process. The authors also include a section on the adaptation of cognitive behavioral techniques to sandtray therapy, which allows the CBT reader a better understanding of how to utilize this approach. The chapter concludes with a review of the literature and a summary that underscores how sandtray therapy lends itself to being an internal and relational process, but also is developmentally appropriate to child and adolescent clients with a variety of difficulties, including trauma histories.

CHAPTER 12

Child-Parent Psychotherapy

ALICIA F. LIEBERMAN
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THIS CHAPTER ILLUSTRATES the use of play in child-parent psychotherapy as a vehicle for increasing parental understanding of the child's inner experience and promoting reciprocity and pleasure in the parent-child relationship. Child-parent psychotherapy (CPP) is a multi-theoretical approach to the treatment of emotional problems in the birth to five age range that focuses on enhancing or restoring the child's mental health by improving the quality of the parent-child relationship. CPP consists of joint sessions with the child and the parent, where play is used as a primary therapeutic modality to encourage developmentally appropriate interactions and to guide the parent's understanding of the meaning of the child's play (Lieberman & Van Horn, 2005, 2008).

Play is the natural medium for psychotherapy because through play children enact and communicate their internal experience and gain increased mastery over their fears and conflicts (Erikson, 1950; Slade & Wolf, 1994). Children who experienced trauma often use play to enact their understanding of what happened. When parents are overwhelmed by their own experience they are frequently unable to understand the significance of the child's play and enter into the play as a way of providing a safe resolution to the child's fears. For this reason, helping children and parents to play together is a primary tenet of child-parent psychotherapy. Rather than becoming centrally involved in the play, the CPP therapist encourages and guides the parent and the child in the process of playing together, intervening primarily to facilitate, explain, interpret, or (if necessary) contain and redirect what is occurring in the play. CPP operates under the premise that, through playing together, parent and child can experience new ways of being with each other that promote trust, mutual pleasure, and a more flexible capacity to repair lapses in emotional reciprocity. The treatment of Alma and her mother, described below, provides an illustration of the use of play as a CPP therapeutic modality.

PRESENTING PROBLEM

Alma was four years old when she was referred to treatment by Child Protective Services after her mother, Mrs. Lopez, reported that her paternal aunt might have abused the child. One evening while Mrs. Lopez was washing Alma's face, the child said that her paternal aunt had hit her in the face many times but told her not to tell anybody about it. When her mother asked her more about what had happened, Alma refused to talk about it. Alma also refused to speak about the incident both with her pediatrician and with the Child Protective Services worker to whom Mrs. Lopez reported the child's disclosure.

Alma was described by Mrs. Lopez and by the child protection worker as sad and oppositional. She was having difficulty in her relationships with peers at preschool. During the initial assessment it emerged that Alma had witnessed physical violence and verbal aggression as well as property damage during fights between her parents, who had separated by the time of the referral. Alma's mother reported that Alma had only limited contact with her father, Mr. Lopez, since the separation. Mrs. Lopez was very concerned that Alma continued to refuse to talk with her about what had happened with her aunt.

During the assessment period, Mrs. Lopez reported that she herself grew up in a home with significant physical violence and verbal abuse between her parents, Mexican American immigrants who had a primary school education, worked long hours, and had difficulty supporting their family. Mrs. Lopez was currently estranged from her parents but maintained a close relationship with her siblings. During the intake she spoke of her feelings of shame, guilt, and inadequacy about her parenting. She struggled with depression, which had never been treated, and described Alma as ''stronger than herself.''

As is the case with many situations of inter generational family violence, there was not one single traumatic event that had affected Alma. Mrs. Lopez was preoccupied primarily by the effect of the aunt's reported abuse, but the family history suggested that Alma was also being affected by the violence between her parents and by the subsequent loss of her relationship with Mr. Lopez. In addition to addressing Mrs. Lopez's concern about the aunt's physical abuse, the treatment plan included a focus on Alma's perception of the violence between her parents, her father's absence from her everyday life, and her mother's emotional availability, which was hampered by Mrs. Lopez's depression.

FRAMING THE TREATMENT

The first treatment session provided an opportunity to explain to Alma the reason that her mother had brought her for treatment. It was clear from Alma's response that the child resorted to taking charge as a strategy to cope with the helplessness and fear generated by her family circumstances, and that she felt brittle when she could not control the direction of the session. When the therapist asked Alma whether she knew why her mother was bringing her, Alma responded, ''I already know everything.'' The therapist commented that Alma already knew that her mom noticed that Alma got sad and mad about scary things that happened at home and wanted the child to have a safe place to find ways of making things better. Alma did not respond verbally, but began to hit her head lightly against the chair saying ''ow.'' Mrs. Lopez looked upset and told her in a soft voice not to hit her head, but Alma continued as if she had not heard her mother. The therapist wondered aloud if Alma was trying to let them know that these feelings were uncomfortable. After banging her head a couple more times, Alma stopped and began to walk around the room, examining the toys.

When she came to the Legos, Alma dumped them on the floor and began to build a tower, telling the therapist about the kind of tower that it was. The mother sat beside the child while playing with her own Legos. Alma's tower fell over, and she responded by looking over at her mom and asking, ''What did you build?'' ''A robot,'' the mother explained. Alma knocked the robot out of her mother's hands. ''Oh,'' her mother responded weakly. Alma told her mother that she did not like boy robots. When the therapist asked her more about boy robots, Alma said that she did not like them because they scared her, and then she moved on to another activity.

When it was time to end the session, Alma protested leaving. Her mother patted her gently in an effort to console her and shepherd her out of the office, and Alma cried out, ''My mom is hurting me! Ow!'' Her mother looked alarmed and upset while protesting that she was not hitting Alma. The therapist intervened by explaining the different agendas of mother and child: Alma wanted her mother to understand that she was having fun and wanted to continue playing, while Alma's mother was trying to leave. Turning to Alma, the therapist added, ''You want your mom to take you seriously.'' Alma answered, ''I want marshmallows! I want to play!'' Her mother said, ‘‘There are marshmallows in the car.’’ Alma continued to cry, but allowed her mother to pick her up and carry her out of the session.

REFLECTIONS ON THE SESSION

Traumatic experiences are as a rule left unsaid, and it is therapeutically important to break the taboo by giving voice to the reason that the family is coming for treatment. In the session above, the therapist tried to provide an explanation for what happens in therapy, but Alma quickly communicated that she did not want certain things said by stating that she already knew ‘‘everything.’’ Not wanting to assume that Alma understood the nature of therapy, the therapist found a way to communicate some basic facts, but did not mention the violence that occurred at home because she thought that Alma's head banging demonstrated her limited tolerance for disclosure. In retrospect, however, it is possible to interpret Alma's head banging as the child's effort to show through her actions what she could not articulate in words: namely, her feeling hurt by witnessing the physical aggression that the parents inflicted on each other. Fear of body damage is one of the central anxieties of early childhood, and Alma was graphically demonstrating that she felt in her body the impact of the physical aggression between her parents.

In framing the treatment for Alma and her mother, the therapist highlighted Mrs. Lopez's motivation to help Alma, casting the mother in the role of a thoughtful and caring parent. By doing so the therapist tried to alleviate the doubts that Mrs. Lopez had expressed about her ability to parent Alma more lovingly than the ways in which she had been raised. Mrs. Lopez had expressed some trepidation about treatment because she feared that it was a demonstration of her incompetence as a mother. She said that she felt stigmatized by her community for coming to therapy with her daughter. The therapist's explicit support had the intention of shoring up Mrs. Lopez's self-confidence and building a therapeutic alliance on behalf of the child.

After the initial brief description of the reason for treatment, the therapist allowed Alma to lead the way. The child began building a tower with the Legos and did not take an interest in what her mother was doing until her tower fell over. She then had an intense reaction to her mother's robot, knocking it out of her mother's hands. Initially the therapist thought that Alma was frustrated because her tower fell down, but Alma explained that her mother had built a robot that scared her. Her statement that the scary robot was a boy raised a question about her perception of males.

Alma avoided discussing emotions directly in this first session, but her emotions were communicated clearly through play. She already seemed to recognize the sessions as a safe place. She brought up fear (the scary robot that her mother made) and violence (interpreting her mother's touch as painful). Alma attempted to control the situation by knocking the robot out of her mother's hand and by protesting leaving the safe space of the playroom. However, she did not resist when her mother picked her up and carried her out of the room. This scene showed Alma's readiness to comply when Mrs. Lopez was able to assert her role as a parent, particularly after the therapist explained the benign nature of the mother's motives in helping her to end the session.

The responses of Mrs. Lopez during the session also showed the range of her feelings as a parent. Initially, she did not respond to Alma's intense affect, seeming frozen and unable to take action to contain her child's head banging and subsequent angry outburst at the robot. This paralysis could have been due to a number of factors: her fear of her own potential for anger and violence, her history of trauma, and her guilt about her self-perception as an incompetent mother. Although the therapist wondered to herself about the dynamic underpinnings for Mrs. Lopez's inaction, she did not explore them because the initial therapeutic focus was on the interaction between Alma and her mother. The central question involved how to help Mrs. Lopez become more proactive in helping the child. The therapist chose to begin with direct observations intended to underline the possible meaning of behavior, a core CPP modality. For example, when Alma banged her head, the therapist wondered aloud what Alma was trying to let them know, and later gave voice to the disagreement Alma and her mother had around the session ending. The therapist's empathic comment about the different points of view that Alma and Mrs. Lopez had about ending the session allowed Alma to leave the session more easily and enabled Mrs. Lopez to take a more directive role. By modeling behavior, the therapist was teaching Mrs. Lopez that she could be assertive in interacting with Alma. Mrs. Lopez incorporated this new way of relating to her child more and more over the course of the therapy.

Alma communicated intolerance for particular affective states with abrupt shifts in her play. Her play was also marked by a strong need for control in response to a home environment where the parents were often out of control. Alma's intense response to the robot that her mother built continued to occur over the course of the next sessions, providing the therapist and Mrs. Lopez with additional opportunities to understand what the child was trying to communicate.

UNFOLDING OF THE TREATMENT

The following week, Alma picked up on the themes that she had introduced during the first session. She instructed the therapist and her mother where to sit and what to play with. She decided to first play with tinker toys and told her mother ''Mom, you can build a robot.'' Her mom did not respond. The therapist commented, ''Last time when your mom built a robot you said it scared you and you did not like it.'' Alma said her Mom could build a ''not scary robot, a girl robot.'' The therapist asked if Alma could tell her a story about a scary robot. The child responded that she could not; her avoidance of unsettling feelings remained firmly in place.

After becoming frustrated with the tinker toys, Alma moved on to the blocks. When the tower she was building fell over, the child responded by violently knocking down her mother's stack of blocks. As in the first session, the mother again responded with a helpless, ''Oh.'' The therapist commented, ''Last time you knocked down your mom's robot because it scared you. You and your mom disagreed.'' Alma turned to her mother and said in a sharp tone of voice, ''You got too close. You have to sit over on this edge,'' showing her mom where to sit. She then relented, shifted the play to the Legos, and told Mrs. Lopez and the therapist that they could sit wherever they wanted. She asked her mom what she was building and her mom said ''a girl robot.'' Alma said that she could build a robot ''like last time,'' but her mother could not find all the same pieces. Alma quickly abandoned the Legos and began to play with lipstick from her mother's purse. She pretended that the lipstick was a laser and that everyone had protective gear on. When the session ended, she said she wanted to keep playing but left easily with her mother.

REFLECTIONS ON THE SESSION

Alma's play had already shifted in the second week. She tried to master her initial responses of fear and anger while struggling not to hurt her mother, a struggle that was clear in her vacillating between expressing her anger and then attempting to make up. It seemed evident that she was concerned about the destructive power of her anger, a fear common among preschoolers.

When Alma attacked her mother's tower after her own tower fell down, the therapist asked herself whether Alma equated the ''bad-behaving tower'' with the ''bad-behaving mother.'' The therapist focused her intervention on the relationship between mother and child, bringing up the prior session when Alma also hit her mother's robot when her tower fell down. By responding that she was angry because her mother had come too close to her, Alma elaborated on the theme of the previous session that the mother's physical closeness and touch might be triggers for a fear of body damage in light of Alma's experiences of violence. Setting a boundary between herself and her mother had its own dangerous ramifications: fear of losing the mother's love is a salient theme in the preschool years, and Alma attempted to repair the relationship by telling the mother that she could sit wherever she wanted and build whatever she wanted. The shift to playing with the mother's lipstick indicated Alma's longing to identify with her mother's femininity rather than aggression, but even this femininity was potentially lethal as represented by the equation of the lipstick with a laser. Alma masterfully protected Mrs. Lopez and the therapist from her aggression by making them wear protective gear so that Alma's weapon could not hurt them. In that way she could both express and contain her aggressive impulses while protecting her love objects.

Alma continued to find boy robots scary, and further identified girl robots as safe. This could speak to Alma's feelings of fear that arose from her parents' violent relationship, and her ownership of her mother's projective identification of her father being dangerous. Additionally, it could demonstrate that the aunt's physical abuse was not the salient trauma and did not significantly impact her sense of safety. As the focus of Alma's play was elsewhere, the therapist did not systematically pursue this topic.

In this session Mrs. Lopez attempted to adjust her play to Alma's wishes. She began to build a ''girl robot'' after Alma specified that this would not scare her. However, she continued to be frozen in her response to Alma's aggression.

A SHIFT IN ROLES

The third session showed that Mrs. Lopez was becoming more actively responsive to Alma. The child started the session by telling mother and therapist where to sit, adding, ''I'm the boss.'' As in previous sessions, she then started building a Lego tower. Also as before, the mother began to build a robot. Alma again hit her mother's robot, but this time Mrs. Lopez had a more nuanced affective response, remarking in a sad voice, ''Oh, you broke my robot.'' Alma reminded her, ''I don't like boy robots. I like girl robots.'' Her mom held up a Lego with a picture of a squiggly mouth and Alma said, ''I don't like that.'' Alma's building then fell apart, and she told everyone to take apart what they had built. Her mom attempted to put up some resistance, asking, ''Why do we have to take it apart?'' Alma replied, ''Because I am the boss.'' The mother's resolve dissolved; she did not answer.

Alma then decided that everyone would blow bubbles, and she instructed one person at a time to blow bubbles and had the other two pop them. This play continued for 30 minutes while Alma laughed and joyfully chased after the bubbles. There was minimal talking as Mrs. Lopez smiled with pleasure while watching Alma blow and chase the bubbles. The therapist commented, ''Your mom has fun playing with you and watching you play.'' Mrs. Lopez responded by touching Alma's foot in a loving way. Alma said, ''Don't touch me.'' The mother looked hurt. The therapist asked, ''You don't like it when your mom touches you?'' Alma answered, ''Only when I'm hurt and she gives me a Band-Aid.'' Alma then continued blowing bubbles.

As it was time for the session to end Alma got some bubble liquid on her clothes. In an upset tone, she said, ''I'm all wet!'' Mrs. Lopez told her, ''It's okay,'' in a soothing voice. Alma made punching movements at her mom and then pretended to cut her mother's throat. Mrs. Lopez appeared surprised by Alma's response. Alma then hugged her mother, and her mother hugged Alma back. When the therapist commented that Alma had many feelings about her mom—anger, fear, and love—Alma made a monster face in response. ''Oooh, it's a scary monster; you don't want me to talk,'' the therapist said. Alma smiled and left the session with her mother.

REFLECTIONS ON THE SESSION

When playing with the Legos, Alma returned to earlier themes by attempting to maintain tight control of the session, but she also showed greater joy and reciprocity than before in her play with the bubbles. The mother's longing for closeness with her child was evoked by the therapist's comment on her enjoyment of Alma's play, but her spontaneous attempt to reach out was met by Alma's clear statement that she only wanted physical contact with her mother when she was hurt.

Over the course of treatment Alma communicated in actions and words her range of feelings about the physical contact initiated by her mother. At times Alma seemed to experience this contact as a misattunement. One example of this response occurred in the first session, when Mrs. Lopez attempted to shepherd Alma out of the office during the first session and Alma did not want to leave. Another example occurred in the present session, when Mrs. Lopez reached out to touch Alma in an unsolicited show of affection while the child was playing with the bubbles. Mrs. Lopez's touch may also be a trigger that reminded Alma of experiences of physical maltreatment. At these times, the child might have responded with a visceral effort at self-protection, perceiving the mother as an attacker and attacking her in response is a classical example of identification with the aggressor as a defense mechanism against fear. This stance may have been at work in Alma's symbolic effort to cut her mother's throat when the mother tried to reassure her that being wet was okay. The fear of losing the mother's love and being sent away like her aggressive father quickly asserted itself over the anger, and Alma hugged her mother in an effort to reassure the mother and herself that love would prevail. Alma put a Band-Aid on the mother's symbolic wound. Her mother again seemed stunned by this outburst, but accepted Alma's affectionate gesture. When the therapist commented on Alma's anger, Alma showed the therapist that interpretations were not welcome at this stage. The therapist openly recognized the disguised monster in Alma's sense of self. Alma enjoyed this recognition. She smiled at the therapist and left the session easily, perhaps reassured by the knowledge that she was leaving the scary, angry part of herself in the therapist's safekeeping.

One of the therapeutic goals of CPP is to foster appropriate physical affection between the child and the parent because this is an important ingredient of healthy child development. Safe physical touch contributes to a sense of safety, self-esteem, and intimate connection in relationships. Particularly when there is a history of trauma and inappropriate physical contact, reestablishing safe touch is an important aspect of treatment. Alma was telling her mother and the therapist what she considered safe touch. Unsafe touch could have had different meanings for Alma. What had occurred with Alma's aunt was still unknown, as was the impact it had on Alma. It is possible that Alma associated physical contact as a prelude to aggression, such as when her parents engaged in physical fights with each other. Although there was no evidence that Mrs. Lopez hit Alma as a form of punishment, the possibility that Alma feared physical contact as a form of veiled aggression because of experiences of being hit by her mother was present in the therapist's mind as she pondered possible meanings for Alma's response.

THE DOCTOR'S KIT

For each session the therapist made available particular toys to evoke experiences of traumatic stress and promote adaptive coping skills. The toys included a family of the same ethnicity as the mother and child, a set of domestic animals, a set of Legos, different kinds of toy cars, such as a police car and ambulance, drawing supplies and a doctor's kit. As Alma resisted talking about the physical abuse she experienced, the therapist made the doctor's kit more prominent in the session as a toy that could be evocative of the abuse and its repair.

A later session began with everyone playing with the Legos. Alma told her mother to make a robot with eyes and a girl robot. She also told the therapist to look for her Lego pieces. She talked about the similarities between her and her mother, and said in a soft tone of voice, ''Mom, I love you.'' Her mom reciprocated, saying, ''I love you.'' Mrs. Lopez found the Lego piece with the squiggly mouth and said, ''Oh, here is the face you don't like.'' Alma took the mouth away from her mom. The therapist asked what kind of a face it was. ''An angry face,'' Alma said. The therapist asked, ''Do you make an angry face?'' Alma said no. The therapist persisted, asking, ''Does your mom ever make an angry face?'' Alma said ''I don't want to do this anymore. You were talking too much. I want to play.'' The therapist answered, ''This is a place where we can talk and play. But I understand that you want to play now and not remember about angry faces.''

Alma moved on to playing with the doctor's kit, putting a Band-Aid on her mother and commenting in response to the therapist question that her mom had a hurt. When asked about how her mom was hurt, Alma did not say anything, but told everyone to clean up. The therapist decided to introduce the trauma Alma had experienced at this time saying, ''Your mom told me about how your aunt hurt you.'' Alma looked confused. The therapist asked, ''Do you ever talk about your aunt?'' Alma did not answer, but she tied the stethoscope in a knot. She then went behind her mother and said that an hour had passed. She came out and held up the stethoscope, the knot was no longer there. ''You took the knot out.'' Alma said, ''It was magic, magic took out the knot.'' Her mother then asked, ''Can you do other sorts of magic?'' Alma replied, ''No, let's play something else.'' Alma then directed the play to Play-Doh. The play was marked by a disagreement between Alma and Mrs. Lopez, with Alma saying that the brown Play-Doh was poo and the mother saying it was chocolate. The therapist again pointed out the disagreement between Alma and her mother. At the end of the session Alma made the pretend phone ring. She picked it up, said goodbye, and then hung up. The therapist asked who called. Alma said that it was her father and that he said, ''Bye.'' She and her mother then left the session.

REFLECTING ON THE SESSION

This session began with the themes of connection and repair. Alma continued to control the play, but she began by talking about the similarities between her and her mom and said spontaneously that she loved her. It was perhaps a signal of Mrs. Lopez's own discomfort with the child's love that she chose soon afterwards to show Alma the toy with the squiggly mouth, which Alma associated with anger and avoided as an intrusion into her efforts to preserve the experience of harmonious love. To repair the empathic breach, she brought out the doctor's kit and tended to her mother. When the therapist insisted on addressing the anger, Alma shifted the play in a further effort to preserve the experience of love.

The therapist, however, had developed a growing conviction that avoiding the themes of violence that had brought Alma into treatment was not helping the child, who continued to express uncontained anger in her relations with peers and continued to be perceived as sad and angry by the child protective worker and by her teacher. For this reason, the therapist decided to introduce the theme of the aunt's hitting Alma's face at this point. Alma's confused response may have expressed her surprise at the therapist's direct confrontation of her avoidance by speaking about a situation that she had steadfastly refused to acknowledge after the initial disclosure. Other explanations are equally feasible given the apparent pervasiveness of physical violence in the parents' relationship. Alma's shift to the magic trick could have been a reference to either the violence in her parent's relationship or what had occurred with her aunt. The knot could have been a metaphor for the conflict that had torn her family apart. Around the time of Alma's disclosure, her parents had their most violent fight. Alma's father subsequently moved out, and afterward Alma no longer saw her aunt.

Strikingly, after this play there was a disagreement between Alma and her mother in interpreting whether brown Play-Doh was chocolate or poo and whether a face was happy or sad. Since the marital separation, Mrs. Lopez had felt safer, but for Alma the separation entailed the catastrophic loss of her relationship with her father. Mr. Lopez's life became unstable after the separation, and he had very limited contact with Alma. What was pleasurable for the mother was the opposite for Alma. The disagreement about the nature of Play-Doh represented a disagreement between Alma and her mother about many key issues: whether the main trauma for Alma had been the physical abuse by the aunt or the intense fighting, abuse, and instability in her parents' relationship and Alma's loss of a stable relationship with her father. Alma had never brought her father into the session before, but she chose to have him come in and leave at the very last moment of this pivotal session. The disagreement highlighted the discrepancy between Alma's despair and her mother's denial of this despair.

During the following session, which occurred after the therapist's absence of two weeks, Alma said, "There is a ghost in here. It's scary in here." The therapist responded that it had been a long time since they had seen each other and asked, "Does it feel scary to be back?" Alma avoided a response and said that she wanted to play, looking through the cabinets for toys. She chose to play with the Legos. She told her mother to make a robot, and she made a tower. When the tower fell over she no longer wanted to play. Later Alma explained why she was the boss: ''Little kids get to be the boss.'' She said that when she plays with younger kids they get to be the boss. Alma was sharing an insight about play in our sessions. Because children communicate through play, it is the youngest one who is the boss of the play. The questions she asked about the ghost remained unanswered: Was she trying to restore her father to the session?

COLLATERAL SESSIONS: SUPPORTING THE PARENT

An important component of CPP is collateral sessions with the parent when the parent's separate input is necessary to maintain the forward direction of treatment. Sometimes adult sessions are necessary for problem solving on behalf of families with limited resources who need assistance with concrete problems of living. Other times the therapist's individual attention to the parent is necessary to convey the therapist's receptiveness to the parent's individual experience. Individual sessions with the parent can take place in a variety of formats depending on the circumstances of each case: The session can be scheduled back to back with the joint sessions, at another time during the week, and if necessary splitting the therapy sessions into a joint component and reserving a part of the time for adult conversation (Lieberman & Van Horn, 2005, 2008).

Mrs. Lopez could not come in for collateral sessions because of her work schedule, but weekly phone check-ins were scheduled to discuss Alma's progress at home and preschool, to discuss what happened during joint sessions, and to ascertain the mother's satisfaction with the progress of treatment. During these phone conversations, Mrs. Lopez asked for guidance on how to talk with Alma about Mr. Lopez. She discussed conversations that she and Alma had at home that paralleled their symbolic disagreements in play. Alma told her mother that she wanted her father to live with them again, and Mrs. Lopez responded to her that it was better for them not live together because the parents fought too much, hurt each other, and frightened Alma. Mrs. Lopez also remarked on how she had noticed that Alma avoided answering questions during therapy but really enjoyed coming to the sessions. She reported that after each session Alma was at ease and talked with her mother about her feelings. Mrs. Lopez believed that there had been significant progress in the sense of intimacy and spontaneity between them, but she was concerned that Alma continued to avoid the topic of her being hit by the aunt. She wanted to bring into the next session two drawings that Alma had done.

THE ABSENT PARTICIPANTS

The next session Alma came in holding her pictures, and showed the therapist a picture with three flowers. ''Daddy is the black flower; mommy is the pink flower with violet and black; I am the pink and violet flower.'' ''Your daddy is black?'' ''He likes black.'' The therapist said, ''Your mommy told me about how your daddy went away.'' ''My aunt and daddy went away.'' The therapist asked about her aunt. Alma responded, ''She is away.'' The therapist commented on the fact that last week she talked about ghosts and that this is a place where they talk about all the people in her life that she did not see anymore, like her daddy and her aunt. Alma responded by saying, ''Do we have to keep talking about this? Can we play?''

The therapist asked her about the other drawing, which was a very abstract drawing with green on the inside and yellow on half of the outside. ''We're in a cave, me, mommy, and daddy.'' She pointed to some black smudges on the picture. ''How did you get in the cave?'' ''Bad guys got us in there. I am reaching for the key.'' ''What does the key do?'' ''It can get us out of the cave. The cave is dark.'' ''How can you get the key?'' ''I have a flashlight, and I can find the key and get us out of the cave.'' The therapist commented that she saved herself, her mommy, and her daddy and that she was taking care of them, and that this was a big job for a little girl. Alma then wanted to stop talking about the drawing and picked out a puzzle to put together, asking her mother and the therapist to help her with it. The session ended when the puzzle was done. The therapist commented on Alma's use of the puzzle as a coping skill, ''It feels good to complete a puzzle together after talking about difficult things.'' Alma did not say anything, but took her mother's hand and easily left the session.

REFLECTIONS ON THE SESSION

Alma's pictures illustrated her concern for her father and her wish for her family to get out of the darkness. She conveyed a striking sense of responsibility: She was the one who could help her family because neither of her parents was able to bring the family to safety. She was not only the boss in the sessions, but by default she was the boss with her parents as well.

Young children often feel responsible for situations in their lives over which in reality they have no control. Reestablishing and clarifying parental responsibility is an important component of treatment. Alma did not want to talk too long about the pictures. At the end of the session she chose an organizing task and allowed her mother and the therapist to help her with it.

SPONTANEOUS PLAY

In the following session Alma drew a picture with five flowers. The flowers were herself, her two godmothers, her mother, and her father. She drew a floating house above them where they all lived. The therapist commented, ''I know you miss having your dad live with you.'' Alma responded, ''My dad is far away.'' She then said that she did not want to draw anymore and added, ''I don't want to be the boss, it is hard to be the boss. There is no boss.'' This was a remarkable relinquishment of the burden of precocious responsibility. The question that her statement raised was: Would there be no boss because nobody had the knowledge and capacity to lead, or because reciprocity was safer and more satisfying than rigid authoritarianism?

A possible answer emerged from the following episode in the session. Alma next chose to play with the Legos. She watched as her mother built something with her own pieces. When Alma asked if it was a robot, her mother showed her the robot she had built. Alma said that she did not like one of its eyes. The mother answered that she would take it off, and she asked Alma if it was better with the eyes removed. Alma nodded her head in agreement. The therapist commented that her mom changed the robot so that Alma now liked it.

Alma then said that she was going to make a laser gun. She put the Legos together. She pointed the laser gun at her mom and the therapist. The therapist asked if they were going to be shot with the laser gun. Alma clarified that the laser gun was to shoot bad guys, and a discussion about the bad guys ensued. Alma explained that everyone had to get the gem without being caught by the bad guys. The therapist asked, ''How are we going to get the gem?'' Alma said that the gem was a pearl and that everyone would use their spy weapons to get the pearl. She asked the therapist what kind of spy weapons she had made. The therapist told Alma that she made a protective shield to keep the bad guys away. Alma wanted the shield, and the therapist gave it to her. Alma connected the laser gun to the shield and held the two together. ''Look at it,'' she said with a proud voice. The mother said, ''You put it together.'' Alma said that each person needed two spy weapons and asked the therapist what she had made. The therapist responded that she made a safe house, which allowed everyone to shrink down and hide in when the bad guys were coming, and a radio to talk with each other. Alma turned to her mother and asked what she had made. Mrs. Lopez said she made a super spy robot that could tell when the bad guys were coming and a protective force field to keep them at bay. ''Let's go find the gem,'' Alma said, and began to tiptoe around the rug, with Mrs. Lopez and the therapist following her. Alma made all of them hit a trap, and Mrs. Lopez got caught. Alma helped her get out, and they continued tiptoeing around the circle. Alma said, ''The bad guys are coming. Let's go into the safe house.'' Everyone got down into the safe house. They then continued tiptoeing around the room, and Alma told her mother and the therapist to jump over a trap. When it was time for the session to end, Alma tiptoed around the room a couple of times and then said that she was ready to stop playing and wanted to go.

REFLECTIONS ON THE SESSION

Alma began this session drawing her reunited family. The fantasy house in which they all lived was not grounded in the reality of the world. It was floating above the fighting and the anger, and everyone was a flower, growing together. The therapist acknowledged how Alma missed living with her father and this explicit link to reality made Alma not want to draw anymore.

Alma then shifted to what sounded like a statement about her evolving sense of herself as a small child, stating that she did not want to be the boss. She touchingly explained how difficult it is to be the one in charge. Her play illustrated this change in control. She returned to playing with the Legos, but she played more cooperatively with her mother. Unlike previous sessions, she did not have an intense emotional reaction to what her mother made. Instead she told Mrs. Lopez calmly what she did not like, and Mrs. Lopez changed the robot accordingly. The play between Alma and her mother had become more reciprocal. Additionally, the robot itself evolved from being a whole ''scary boy robot'' to having just one scary eye. This evolution speaks to the change in the mother-daughter relationship, which shifted from being fixed in opposites to being more flexible and symbiotic.

Along with this reciprocity, Alma became more creative and spontaneous. She was receptive to each of the spy weapons her mother and the therapist made and incorporated them into the game. She established a narrative that included all three playing together, working toward a common goal. Her relinquishment of the rigid need to be the boss enabled Alma to lead her mother and the therapist in a play in which she encountered and overcame imaginary obstacles in an age-appropriate way.

CONCLUDING REFLECTIONS

This case illustrates the evolution of play in CPP. Through play the child and the parent learn to communicate and repair areas of fear, stress, and misattunement. Alma was brought to therapy because her mother was concerned about the physical abuse by her aunt, yet for Alma the more salient trauma was the fighting between her parents and her father's absence, something that was difficult for Mrs. Lopez to discuss. This disagreement came out in Alma's play with her mother. Mrs. Lopez was initially paralyzed by Alma's angry and rejecting response to her. Through modeling by the therapist, the mother was able to begin a conversation with Alma that continued outside the sessions. Despite Alma's protest at different points during the therapy, she continued to enjoy coming, often refusing to leave. Alma's play toward the end of the therapy became more spontaneous and open. She was also beginning to accept her mother's contribution to the play.

When Mrs. Lopez first brought Alma to therapy, she and Alma were not able to communicate with each other or to understand each other's experience. Over the course of therapy, Alma used play to communicate to her mother the impact that the violence at home and her father's absence had on her. Mrs. Lopez, in turn, learned how to speak Alma's language; she learned how to play with her daughter. As they played together they were both able to feel more connected with each other and more fulfilled in their relationship, and this led to richer play. Through this new experience Alma began to speak about her feelings with her mother.

As the case illustrates, play is the foundation of CPP. Within the setting of play, the parent begins to understand the child and also begins to understand their parenting. The therapist helps this process along by entering the play when needed to explain, educate, interpret, and reframe. It is through this play that the child and parent begin to understand each other and their experiences.

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CHAPTER 13

Filial Therapy

Theoretical Integration, Empirical Validation, and Practical Application

RISË VANFLEET

FROM THE EARLIEST days of Filial Therapy in the late 1950s, its founders, Drs. Bernard and Louise Guerney, conceived and developed it as a theoretically integrative model. This type of theoretical cross-fertilization was rare at the time, but 50 years later this empirically validated approach has been increasingly embraced by clinicians and family educators throughout the world. This contribution offers an overview of the Filial Therapy process and its theoretical foundations, followed by more detailed descriptions of the play therapy and cognitive behavioral therapy aspects of this intervention. A summary of more than 40 years of research is also included.

OVERVIEW OF FILIAL THERAPY

Filial Therapy (FT) was the first of the family of Relationship Enhancement® approaches to be developed, with the initial professional article published in the *Journal of Consulting Psychology* (Guerney, 1964). It is a form of family therapy in which the therapist trains and supervises parents as they learn to conduct nondirective play sessions with their own children. As their competence and confidence in conducting the weekly play sessions grow, parents transfer them to the home environment. During this transition period, the therapist continues to monitor the play sessions and helps the parents generalize the skills and interactions that they have learned for use in daily life. The special parent-child play sessions can continue independently after discharge from therapy as a means of enriching family relationships and preventing further problems.

To date, FT has been practiced most frequently by play therapists in North America and abroad, but family therapists, psychologists, social workers, counselors, and psychiatrists have shown growing interest in the approach. The American Psychological Association recently produced a DVD about the approach (VanFleet, 2008), and other FT materials have been used by professionals in over 65 countries, with a number of translations available.

Filial Therapy uses play as the primary medium for strengthening family relationships, building parent-child respect and understanding, and resolving child and family problems. Play is the primary way that children express themselves, accommodate and assimilate the world around them, develop attachment relationships, and progress on a host of developmental dimensions (Chudacoff, 2007; Elkind, 2007; Ginsburg, 2007; Spiegel, 2008; Sutton-Smith, 2008). Play serves as the most child-friendly way for parents and other caregivers to understand the child's feelings, motives, perceptions, thoughts, and behaviors. In essence, play represents children's first ''language,'' so its use in therapy is critical for adults to comprehend more fully the culture of childhood.

Filial Therapy is most applicable to children 2 to 12 years of age, as this is the time period when they are most likely to play symbolically and imaginatively. Adaptations are made for special times with older children. Children with histories of trauma and attachment disruption often lag behind their chronological age in their social and emotional development, and FT has been used as described here with maltreated children as old as 16.

Filial Therapy can be conducted in groups (Caplin & Pernet, in press; Guerney, 1983; Landreth & Bratton, 2006; VanFleet & Sniscak, in press; Wright & Walker, 2003) or with individual families (VanFleet, 2005, 2006a). It has been used as prevention with at-risk families or families with few difficulties as well as an intervention with a wide range of child and family problems in a variety of settings (VanFleet & Guerney, 2003).

THE GOALS OF FILIAL THERAPY

The goals of FT are to teach and facilitate parents as they create a safe, accepting environment in which their children can express their feelings fully, gain an understanding of their world, solve many of their own problems, and develop confidence in themselves and their parents. Filial Therapy is designed to help parents become more responsive to their children's feelings and needs, to become better at solving problems that arise within the family, and to become more skillful and confident as parents. After participating in FT, families typically demonstrate better communication skills, interpersonal problem-solving skills, and stronger family relationships. Filial Therapy helps create a network of healthy, secure attachment relationships within the family. Most families report that the process is enjoyable and that everyone in the family becomes more playful, accepting, and flexible as a result (VanFleet, 2005, 2006b).

PLAY SESSION SKILLS OF FILIAL THERAPY

In Filial Therapy, parents learn to conduct special nondirective, or child-centered, play sessions with their own children (VanFleet, 2006a, 2006b, 2006c). The sessions are held with one parent and one child at a time, although parents often observe each other's play sessions, and attempts are made to include all children in the family in the process. Nondirective play sessions are used because they are relatively straightforward for parents to learn and because they provide an avenue for children to express and master their feelings and concerns, often resolving their own problems, and communicating their hopes and dreams. The nondirective nature of the play sessions also helps parents understand and appreciate their children *as they are*, without adult orchestration or direction. Perhaps most important is the attachment-building function of nondirective play sessions (Wilson & Ryan, 2005; VanFleet & Sniscak, 2003), in which parents and children become more attuned within the context of the child's world.

In order to become effective in FT, therapists must become skilled in child-centered play therapy, as well as proficient in working with parents and families from a systemic perspective. They must have experience with the four basic skills of child-centered play sessions, an understanding of accurate interpretation of play themes in the context of the individual children's and families' lives, and empathy and respect for parents rooted in a completely collaborative approach to therapy. Once they can practice what they preach, they are ready to engage parents in the process.

Parents learn four basic skills for use during the actual play sessions, all of which can be generalized at a later time for use in daily life. The skills are briefly described below and detailed in VanFleet (2000, 2005, 2006a, 2006c).

- **Structuring:** This skill helps children understand the climate of the play sessions, informing them about what to expect. Parents learn how to present the play sessions to their children, what to say when starting the play sessions, and how to manage room departures at the end of the play sessions. They learn how to handle potential resistance from the child, especially with regard to the departures.

- **Empathic Listening:** This skill helps parents put their own thoughts and feelings temporarily aside and truly listen to the children's verbal and nonverbal communications. Parents allow the child to lead the way by refraining from teaching, questioning, suggesting, or directing the content of the play during the special play sessions. Instead, parents briefly rephrase aloud the child's main thoughts, feelings, and behaviors, thereby conveying their interest, understanding, and acceptance. Parents demonstrate empathy and attunement to the child in this manner.
- **Child-Centered Imaginary Play:** This skill offers the child another form of attunement and empathy. When children play by themselves, the parents use empathic listening, but when they invite their parents to play with them, the imaginary play skills take priority. The parents engage in pretend play when the child requests it, and they play their assigned roles in accordance with the child's wishes. With this skill, parents behave much like an actor following the child's direction so that play themes of importance to the child can develop.
- **Limit-Setting Skill:** This skill ensures the safety of child and parent and provides boundaries when needed. Although the number of limits is minimized during the play sessions, there are times when parents must enforce rules to protect people and property and to help children develop self-regulation and responsibility for the outcomes of their behavior. Limits help children learn to redirect their energies when their behavior is destructive or unsafe. Parents learn a three-step approach to limit setting: (a) when a boundary is first broached, parents state the limit specifically and behaviorally, and redirect the child in a general way; (b) when the child breaks the same limit a second time, the parent reminds the child of the rule and adds a warning, informing the child that the play session will end if the same rule is violated a third time, and then redirects the child in a general way again; and (c) if the child breaks the same limit a third time, the parent enforces the consequence by ending the play session. This process quickly reestablishes parental authority when needed. Because even very distressed children are highly motivated to play in this manner, they usually self-correct or redirect their energies during the first two steps of limit setting.

These four skills are used *during* the parent-child (filial) play sessions. The therapist helps parents develop a fifth skill, *play theme interpretation*, during discussions *after* each play session during which the child is excused to a safe area or to child care and is not physically present. Here, the therapist helps parents identify repetitive or intense play episodes, or patterns of play, and develop alternative explanations of their possible meanings. These interpretations are not shared with the child, but they further parents' understandings of their children and facilitate other family changes that might help.

Some might note the absence of the use of reinforcement with children during the play sessions. While filial therapists do train parents in the use of reinforcement methods near the end of the process, reinforcement is never used during the play sessions themselves. Because the nondirective play sessions are based on Rogerian principles, elements of judgment or potential criticism are removed. The play sessions aim to permit free expression by children, and when reinforcement is introduced, it begins, by definition, to alter the behavior. In FT, the therapist uses the play sessions to permit children one time during the week when they can be free to be themselves without so much of the adult direction that is necessary in rest of their lives, and it seems valuable for parents to begin to see their children *as they are*. Use of reinforcement with children during play sessions would reduce or eliminate the sense of acceptance so important to this form of play therapy by introducing the element of judgment. The focus of FT is on relationship-building rather than behavioral compliance. Filial therapists value the power of reinforcement, but they help parents use it in daily life, not within the play sessions.

THE SEQUENCE OF FILIAL THERAPY

Filial Therapy is remarkably flexible, allowing adaptations for different families, settings, problems, cultures, timeframes, and individual family needs. Filial Therapy typically requires between 15 to 20 one-hour sessions with individual families, and FT groups usually meet for two hours and last from 10 to 20 weeks. Families with complex problems might take longer. While there certainly are differences among the various formats of Filial Therapy that are in use today, they generally follow the same sequence.

VanFleet (2000, 2005, 2006a) has detailed the process of Filial Therapy elsewhere, but a brief description follows. First, the therapist conducts an intake with the parents, followed by a family play observation. In this, the therapist observes the family playing together for approximately 20 minutes in the playroom, prior to the family's receiving any training. The therapist then asks parents to share the similarities and dissimilarities of the family play to their dynamics at home, empathically listens, and asks questions to clarify family goals for therapy.

Second, the therapist explains the rationale and methods of FT, inviting questions, empathically listening to concerns, and engaging parents as partners in the process. Parents are encouraged to raise doubts and concerns about the recommendations so they can be discussed openly.

Third, the therapist demonstrates brief individual nondirective play sessions with each of the children in the family while parents observe, and then discusses the play sessions fully with the parents, listening carefully and addressing parents' questions or concerns once again. Many parents are eager to become involved, but some express anxiety or reluctance to participate, and the therapist again responds in an empathic, accepting manner. This early attention to the parents' needs typically results in their eventual full participation in the process.

Fourth, the training phase begins, in which the therapist teaches the play session skills to the parents. Therapists use a multimodal training approach involving brief description of the skills, therapist demonstration, skill practice by parents, and coaching and feedback from the therapist. Training culminates in two mock play sessions with each parent. The therapist and parent move about on the playroom floor while the therapist pretends to be a child at play. The parent attempts to use the four skills they have just learned. The therapist coaches them as they try, and at the end of the mock session, the therapist discusses parent reactions and provides feedback, the overwhelming majority of which is positive and specific. The therapist also offers one or two suggestions for skill improvement. When two or more parents or caregivers are participating, all the parents observe each other's mock play sessions and feedback, learning from each other.

Fifth, the parents hold play sessions with their own children, one at a time, under the direct supervision of the therapist. All the children are involved, and parents take turns playing with each of them from week to week. Adolescents usually take part in special times with their parents rather than in play sessions with toys. After each 20- to 30-minute filial play session, the therapist meets with parents alone, providing them with skill feedback and discussing possible meanings of each child's play. At all times, the context of the child's life is considered when developing hypotheses about the play themes. As filial play sessions continue, family dynamic issues inevitably emerge, and the therapist helps the family understand them and problem solve them as needed.

Sixth, parents begin to hold play sessions more independently in the home setting. They typically develop proficiency in their skills after four to six supervised play sessions, and the transition happens at that time. The therapist still monitors the home sessions in weekly or biweekly meetings with the parents, and then begins the generalization process. The therapist helps parents adapt the skills for use outside the play sessions and teaches additional parenting skills. The family continues to hold filial play sessions, even after therapy ends, as long as the children and family benefit from them.

THEORETICAL FOUNDATIONS OF FILIAL THERAPY

The reader has probably already recognized a number of theoretical applications at work in Filial Therapy. From its start, FT has blended a variety of theoretical orientations into a comprehensive whole. This section briefly describes the range of theories that make up the foundations of FT and refers readers to resources that explore all of them more fully.

The words of Louise Guerney (2003) provide insight into the essential nature of FT: Filial Therapy is an educational model of intervention. The educational model posits that change takes place through the acquisition of new behaviors or skills that replace inappropriate behaviors. This is accomplished through systematic skills training methods. In the educational model, the skills for effecting positive changes in others may be taught to therapeutic agents or change agents who are paraprofessionals or nonprofessionals and delivered by them to clients with the training and supervision of a professional (Guerney, Stollak, & Guerney, 1970; Authier, Gustafson, Guerney, & Kasdorf, 1975). It is a completely different model of service delivery from the traditional medical model, and considers *training* to have positive treatment effects.

FT is a theoretically integrated approach including elements of humanistic and behavioral therapies. Behavioral methods are used to teach parents the skills of conducting the play sessions. Modeling, role-plays, and behavioral rehearsal are employed with heavy emphasis on reinforcement for all small steps forward. All of the skills training is conducted in an atmosphere of acceptance, empathy, warmth, and positive regard (i.e., using the Rogerian principles) (Rogers, 1951, 1969) that optimize learning and change. Supervision is thus addressed both to the parents' use of the play therapy *skills* and their *feelings* about the process of learning and intervention in which they are engaged. Since they are the providers of the intervention for their children, the goal of proficient use of skills is always in the foreground, but the background in which this teaching is embedded is their affective state. The two domains are entwined—the reason for our referring to FT as a ''didactic and dynamic method'' (Andronico, Fidler, Guerney, & Guerney, 1967). It is quite amazing, however, to see how, for example, a parent's efforts to learn to set limits effectively in the play session is often relevant to broader, long-standing boundary issues which are cleared up in the course of resolving the limit-setting difficulty. Other interpersonal and affective issues frequently relate quite directly to appropriate application of the skills with their children, making for gratuitous personal growth gains for parents as they become more empathic and exercise better controls.

Filial Therapy is comprised of contributions from diverse theoretical orientations, including developmental and attachment, humanistic (Rogerian), psychodynamic, behavioral and social learning, cognitive, interpersonal, and family systems. Although the basic assumptions about human development and change processes vary considerably among these theories, they are united comfortably within FT, most likely because of its psychoeducational nature. The applications of these theories operate throughout the FT process to impact the children, the parents, their relationships with each other, and the family as a whole. It is important to remember that in FT, the client is neither the child nor the parent, but the *relationship*. Filial Therapy is designed, first and foremost, to strengthen parent-child and family relationships. Behavioral compliance is not a key goal, but the improved relationships almost always result in better child behavior in a relatively short time. More substantial descriptions of the contributions and manifestations of these theories within FT are available elsewhere (Cavedo & B. Guerney, 1999; L. Guerney, 2003; Ginsberg, 2003, 2004). The reader should bear in mind that all of these theoretical applications and contributions to FT are essential and important ingredients for its practice and effectiveness. For the purposes of this volume, however, and to meet space requirements, the remainder of this chapter focuses primarily on the influence and integration of nondirective play therapy (humanistic orientation) and cognitive behavioral therapy.

THE RELATIVE CONTRIBUTIONS OF PLAY THERAPY AND COGNITIVE BEHAVIORAL THERAPY IN FT

Although it's certainly possible to conduct other interventions in conjunction with Filial Therapy, such as individual play therapy (PT) or cognitive behavior therapy (CBT), it is often unnecessary because FT incorporates strong elements of both throughout its process. B. G. Guerney (1977) has commented, "It is our view that the educational methods exemplified by the RE programs (author's note: Relationship Enhancement® programs, which include FT) would be far more beneficial in the majority of cases than traditional individual or group psychotherapy. However, we do not in any sense see such programs as being *incompatible*, concurrently or sequentially, with psychotherapy or other forms of psychiatric treatment'' (p. 22). Therapists who have full training and supervised experience in FT often comment that it addresses most child and family needs directly and that additional interventions are needed only in the most severe, multiproblem cases. By addressing the essential and pivotal attachment and relationship needs of all family members, FT seems to reduce the need for adjunct therapies. Most are represented within the process itself.

Filial Therapy is deceptively simple. The process is straightforward, and it appears that the therapist simply teaches the parents skills; the parents use them in play sessions with the children; the children's presenting problems get better; the parents feel more confident and satisfied; and family relationships are stronger. Behind this, however, the therapist must thoughtfully and effectively respond to the needs of the children and parents, and work with the dynamics in the family relationships to ensure the family's success. In FT, family members retain control of the *content* of the therapy while the therapist is in charge of the *process*.

The play therapy component of FT is nondirective for reasons stated earlier. Child-centered play therapy is based upon Rogerian principles, as adapted by Axline (1947, 1969). Parents use the play session skills to create an atmosphere of safety and acceptance within which children are free to express, explore, and develop their *selves*. During the play sessions, parents must refrain from very natural and normal parental behaviors, such as asking questions or making suggestions, and genuinely attend to and show understanding of the child's feelings and interests. For that half hour each week, the child can count on the parent's undivided attention and positive regard. This process helps create, or re-create, healthy attachment relationships within which children develop confidence in themselves and their parents. The filial play sessions help parents create a more secure base from which their children can explore themselves and their world. Coincidentally, parents also feel the effects of the healthier attachment relationship, and often relax and enjoy their relationships with their children more fully. Relationships have reciprocal influences, and FT helps move these in positive directions for all involved.

The nurturant, accepting nature of the filial play sessions extends to all of the child's feelings and motives, but not necessarily to all behaviors. While the environment of the play sessions is designed to reduce the need for many limits, there are times when children's behavior becomes unsafe. At those times, parents move from use of the empathic listening or imaginary play skill to the limit-setting skill. Boundaries are important for children to feel safe and to help them take responsibility for themselves—to ground the therapy in reality, as Axline noted in her principles of nondirective play therapy (1969). From the children's point of view, it is the balance between empathy and boundaries that provide the safe context within which they can express themselves without hesitation, try out solutions to their problems without fear of reprisal, and feel closer and more trusting of their parents.

The use of empathy and acceptance applies to parents as well. The therapist extends the Rogerian principles to parents in much the same way as they help the parents apply them with their children. At all times, the therapist genuinely empathizes with parents' feelings and concerns, helping them feel accepted and engaged. Filial therapists share a fundamental belief in parents' abilities to solve many of their own problems in this context, which parallels the belief that children can resolve many of *their* issues in the play session context. Throughout the FT process, therapists model the attitudes and skills that they are helping parents develop with their children. Not only does this assist parents' learning process, but it also helps them feel respected, engaged, and understood, factors that contribute to a true collaborative working relationship. In this, one can see the interplay of humanistic, behavioral, and relationship principles to achieve therapeutic success for the entire family.

Empathy is an important part of FT at all times. The therapist shows empathy to the parents, and the parents show it to the children. The therapist employs behavioral and social learning components heavily during the training process, and continues their use as they supervise the filial play sessions. Cognitive therapy components might be used at various times in FT, but seem most relevant during the feedback sessions during which the therapist is helping parents understand their children's play and their own reactions to it. The sections that follow explore these components at key phases of the FT process.

INTAKE AND RECOMMENDATION PHASE

When first discussing parental concerns, the therapist empathically listens, attempting to understand parents' feelings at the deepest levels. This often produces much more relevant information than traditional questioning techniques, with the added benefit that the therapist-parent relationship develops into a partnership from the earliest meetings. After the initial meeting with parents and the family play observation and discussion, the therapist recommends FT when appropriate. During the recommendation phase, the therapist shares the values and principles underlying FT as well as specific information about what to expect in a very specific, honest, and transparent manner (VanFleet, 2000). Parents are fully informed so that they can make the best choices for their family. If they raise questions or objections, the therapist empathically listens to ensure understanding before responding or explaining further. The key is to help parents see the potential relevance of this approach for their problems, especially since it is not likely what they were expecting. Families seem to appreciate this level of inclusion. This discussion of expectations, goals, and methods fully engages parents in the decision-making process, modeling the respect and empowerment so characteristic of FT. The level of clarity, as well as the emphasis in FT on present-day adjustment rather than past dysfunctions reflects both humanistic and cognitive behavioral principles at work.

For example, after a therapist has recommended FT to a parent, the parent replies, ''I just don't see how this can work. I've already tried everything I can think of. Can't you just work with the child?'' To this, the therapist responds, ''It must be so discouraging and frustrating to keep trying things that don't seem to work. You doubt whether you have it in you to be successful. I can see you have tried very hard to be a good parent, and there are many things that you've done really well. With FT, you don't have to go it alone. We'll be partners in the process. You're the world's best expert on what your child is like, and I have expertise in this particular method. I think together we could make a great team and could finally get through this problem. Would you be willing to watch me have one of these play sessions with your child next time, and then we can talk further?''

TRAINING PHASE

Behavioral methods predominate the training phase of FT, although the therapist continues to be empathic and accepting throughout. Principles of operant conditioning and social learning theory help ensure parent motivation and success.

The training model of FT has four distinct steps: description, modeling, skills practice, and feedback (L. Guerney, 1983; VanFleet, 2005, 2006a).

Description: The therapist first describes each of the four play session skills, including the rationale for its use, the methods (e.g., what words to say, gestures or other nonverbals), and examples (usually drawn directly from the play session demonstrations that the therapist has conducted with each of the family's children the week before). Descriptions are kept short, and the therapist does not expect parents to remember all the details.

Modeling: The therapist then provides a model of the skill. Sometimes this is accomplished during the play session demonstrations, or with DVD examples or live role-plays. The best modeling seems to be the most relevant—that is, when parents watch the therapist hold nondirective play sessions with their children.

Skill Practice: The therapist next helps parents practice the skills. Perhaps one of the most effective and efficient ways to do this involves the mock play sessions, which in essence are behavioral rehearsals for the actual play sessions. For 10 to 15 minutes, the therapist pretends to be a child and plays in a manner that permits the parents to practice each of the skills. For example, the therapist waits while the parent makes the room entry statement (structuring), plays by him- or herself to give the parent practice in empathic listening, invites the parent to play a specific role (child-centered imaginary play), and pretends to break one of the obvious rules so the parent can practice limit-setting skill. The therapist tailors the play to the parent's ability, maintains a lighthearted climate, and provides short encouraging statements and in-the-moment positive reinforcement. This process represents the shaping principle at work. Steps in the right direction, no matter how small, are successes for the parents and are recognized as such by the therapist.

Prompting and modeling are also used during the mock play sessions. If parents are missing key aspects of one of the skills, the therapist can cue or prompt the parent in the moment, essentially giving a hint, such as ''You're doing a great job describing what I'm doing. Look at my face—can you say what feeling I seem to have?'' When the parent complies, then the therapist reinforces the effort. If parents are very quiet or simply do not know how to respond, the therapist models the actual statement for them, such as ''Why don't you say something like, 'You're worried that the blocks are going to fall.' '' Even if the parent uses the therapist's words verbatim, the therapist reinforces. The amount and timing of such prompts or modeled statements is important to avoid giving parents the idea that they are incapable. These interventions are used sparingly and only to ensure that the parent succeeds. Once again, the shaping principle must guide the therapist's comments rather than any perfectionistic tendencies the therapist might have!

Shaping is used in a broader way during the training phase as well. The therapist holds at least two, and sometimes three, mock sessions with parents. Each one becomes a bit more challenging as parents' skills develop.

Learning to conduct mock sessions can be quite challenging for therapists, as they must apply play and behavior principles almost simultaneously.

These are very different mental processes. The therapist must play in a realistic manner while watching the parent's progress and reactions carefully, adapting that play as needed to ensure the parent's success. At the same time the therapist uses behavioral skills to provide immediate feedback and coaching to parents, thereby relieving their anxiety and maintaining their motivation. Once learned, mock sessions are an invaluable tool for helping parents learn the play session skills quickly and well.

Feedback: In addition to the immediate feedback provided during skill practice (mock sessions), the therapist offers more detailed feedback at the end of the mock play session. The therapist asks the parent to talk about what it was like: ''What skills were easiest to use? Which were more difficult?'' After empathically listening to parent reactions, the therapist provides detailed skill feedback. Great emphasis is placed on being positive and specific: ''When I was throwing the blocks in your direction, you raised your hand and spoke my name. I could hear how your voice changed and sounded firm. That was a wonderful example of limit setting.'' At least 75 percent of this feedback focuses on things the parents did well. The therapist also gives suggestions for improvement. Usually just one or two improvements per session are sufficient to facilitate progress without overwhelming or discouraging parents. Emphasis is on what parents could do differently rather than on what they did wrong: ''I liked the way that you described how I was arranging the doll house. You didn't ask any questions or help me unless I asked. That was terrific! Next time, see if you can notice and mention more of my feelings. For example, when I held up the toilet and giggled, you could say something like, 'You're surprised to find a toilet here, and that's funny to you.' Keep up the great work!''

Giving specific examples helps link the reinforcement to parent behaviors more precisely, thereby enhancing the value of the information. To an outsider, it may appear that the filial therapist becomes quite excited by skills that are rather rudimentary, and this has at times been misinterpreted as disingenuousness on the part of the therapist. In actuality, it is very sincere feedback. The difference in these interpretations lies in the yardstick that one uses to measure progress. When compared to a highly skilled play session, parents' early efforts simply wouldn't measure up, but when compared to the parents' prior skill levels, each improvement heralds progress, and filial therapists are genuinely excited to see this. From a Rogerian point of view, filial therapists must be *congruent*. A working knowledge of the behavioral shaping principle allows their feedback to be sincere.

From social learning theory, filial therapists also capitalize on the advantages of vicarious learning during the training phase. When there are two or more parents or caregivers involved, the therapist holds a mock play session with each parent while the others observe. They also observe each other's feedback processes. In this way, parents learn a great deal from each other's practice and feedback. They often comment about how it becomes easier after they have watched someone else. Sometimes parents who are unsure of their own skills ask their spouses to participate in the mock sessions first so they can observe. Then when it is their own turn, they borrow some of the same phrases or feeling words that their spouses used in the previous practice. This illustrates the power of vicarious learning. It is quite common in FT groups for the parents who have their mock sessions last in the rotation to appear considerably more skilled than those who try it first.

Some of the short-term group adaptations of FT do not use mock play sessions, instead having parents practice in dyads rather than with the therapist in front of the entire group. There are, of course, pros and cons to all methods, and this approach probably saves time and reduces parental anxiety, but some of the behavioral and social learning benefits are likely diminished. Using mock play sessions, the therapist has greater control of the process, and both shaping and vicarious learning contribute substantially to parents' skill development. Whenever possible, therapists are encouraged to use the mock play sessions to obtain high levels of skill development in a relatively short period of time.

In general, this positive behavioral approach to skill development builds parents' motivation and confidence. There appears to be a cognitive shift as well. Parents' self-perceptions seem to change, as evidenced by common comments such as the following verbatim quotes:

- This is fun—easier than I thought it would be.
- I think I'm getting it. Each time it gets a little easier.
- I went to a parent training program a few years ago, and I think I've read almost every parenting book there is, but this is the first time anyone has ever told me the things I'm doing right. I'm not such a bad parent after all!

SUPERVISED PLAY SESSION PHASE

As parents start the actual play sessions with their children, they typically have a grasp of all four skills, although they may not yet be proficient in them. The therapist helps them continue to develop their skills during the first few filial play sessions, whereupon most parents become quite skillful. Early research demonstrated clearly that parents are capable of learning to conduct nondirective play sessions at a level comparable with play therapists. Raters used behavioral codings of play sessions conducted by therapists and by parents, remaining blind as to condition. No significant differences were found (Andronico & B. Guerney, 1969; Stover & B. Guerney, 1967).

During this phase of FT, the therapist observes the half-hour parent-child play sessions. Observations can be made from behind a one-way mirror, via closed-circuit television or wireless camera-computer connection, or from an unobtrusive seat in the corner or just outside the playroom. All seem to work equally well. The therapist observes and records process notes for reference, but does not interfere with the filial play session unless there's an emergency situation. Therapist coaching *during* a play session does not convey an empowerment message and could undermine parental authority with the child. Furthermore, parents need not be perfectly skilled in order to reap the benefits of the play sessions. Children are usually very excited to play with their parents in this manner. Therapists continue to be content with successive approximations toward the goal of well-conducted play sessions; that is, they must have patience and focus on the small steps of progress.

After the filial play session, children are excused to a safe waiting area or to child care, and the therapist meets with the parents alone. Once again, if there are two or more parents, they observe each other's play sessions sitting beside the therapist and listen to the feedback dialog. The therapist uses the same feedback process as in the training phase, giving parents a chance to self-critique, offering praise and encouragement for specific behaviors in the play session, and making just one or two suggestions for improvement.

At this point, filial therapists also focus on play therapy and family dynamic factors. This includes discussion of play themes and parents' personal reactions to the play sessions. Initially, this discussion is rather short compared to the skill feedback, but as parents improve, this relative emphasis is reversed. Once parents are skillfully conducting their play sessions, the feedback consists of shorter discussions for skill refinement and longer discussions of the play itself. Therapists rarely need to introduce the play interpretation skill in a didactic manner. Instead, they elicit parents' ideas about what the play might mean and offer their own ideas. To encourage parents to share their thoughts about the play, they might ask questions such as those listed below.

- What did you notice about the play? Any idea what that was about?
- Did you notice parts of the play that were repetitive? Intense? Have you seen a pattern in the play over the past few sessions?

- What emotions was your child expressing? Have you noticed similar situations and feelings at home, school, or in the neighborhood?
- Does this play remind you of anything?

Filial therapists strive to help parents understand the children's play *in context*. Often the parents know more about the context than the therapist, so their input is very important. The therapist and the parent need not come to a definitive interpretation of the play, however. Much of the play theme discussion takes the form of possible alternative ''theories'' or hypotheses about the meanings of the play. The therapist shares his or her own ideas as well, and this process seems to help parents become better at understanding their children's feelings and motivations, which is the primary outcome desired.

By participating in their children's play and discussing it with a warm, accepting therapist afterward, many parents automatically begin shifting their views of their children and themselves. As they become more open to the child's expressions, dilemmas, coping, and problem solving within the play sessions, they often shift their way of thinking about the child. One of the most common shifts that occurs involves parents beliefs about children's motives. Often parents enter FT with comments that their children are deliberately misbehaving to make them (the parents) angry. Usually within just two or three play sessions, parents begin to see the anxiety or stress the child is feeling, and they change their attributions of the children's motives, sometimes quite suddenly.

An aunt and uncle were raising two young boys after the parents were imprisoned for selling drugs. The four-year-old was very oppositional. The aunt and uncle were extremely frustrated with his ''willfulness'' and ''need to get his own way all the time.'' This boy loved the play sessions with his aunt and uncle, and in just two sessions they began to see the extreme anxiety that had been masked by their focus on his misbehavior. Both times, he organized the small soldiers in a battle scene in the sandtray. He placed a single soldier at one end of the tray facing all the rest of the soldiers and tanks. In the ensuing battle, complete with shooting and bombing sound effects, the lone soldier died and was buried in the sand. The boy commented that the soldier stood alone and just was not strong enough for the enemies. During his second play session, he actually said, ''They're all shooting at me. No place to go. Quick, take cover!'' This seemed to confirm the hypothesis that the play represented his feelings about his own life and position vis-à-vis the world. Whether or not this was an accurate interpretation of his play, his aunt and uncle had a revised understanding of his behavior, and this made it possible for them to make better parenting choices. They stopped asking him *why* he behaved badly, avoided verbal power struggles, reflected his feelings when he was upset, encouraged him when he was frustrated with tasks, and set firm limits with reasonable consequences when he misbehaved. After just 10 play sessions, his oppositional behavior nearly disappeared, and it had not returned two years later when the aunt and uncle contacted the therapist to inform her of a school honor that the boy had received.

Although parents often change their perceptions on their own as their understanding of their children deepens, there are times when the therapist plays a more active role to help parents cognitively restructure their interpretations. This happens when parents have exceptionally strong reactions to the play session or to the child. The therapist does not whitewash difficult material the child presents in the play, but helps parents understand it rather than be threatened by it. For example, a mother who had been a victim of domestic violence held her third play session with her 8-year-old son. His play was quite aggressive, although he immediately stopped kicking the bop bag when his mother set a limit. Afterwards with the therapist, the mother voiced concern that the play sessions were doing more harm than good. With ample empathy, the therapist eventually helped the mother realize that she had been frightened by the boy's play, with thoughts that he was going to turn out like his father. The therapist then helped the mother gain a new understanding of his play by educating her about trauma-related play; by highlighting that the mother ultimately was in control of the play session and that the boy had responded appropriately to her limit; and by discussing the mothers' worst fears (that the boy would hit her) and how she would manage it (with specific information about limit setting and room departure should he push it to the third infraction). The therapist then helped the mother see that her worst fears were unlikely because he had already demonstrated that he wanted to comply with her limits and continue to play with her. When the mother felt more in control of the situation, she readily agreed to continue the play sessions, with the new realization that his play could relate to his own fears about the domestic violence that he had witnessed.

In situations where parents have difficulty understanding or accepting the child's play, the therapist first ensures that they know how to use their skills to handle the uncomfortable situation and then helps them cognitively reframe their understanding so they can move forward with the process. Parents' reactions are always affirmed and normalized, given the circumstances, and great care is taken to avoid any hint of judgment or criticism. The key to success is truly understanding the parents' feelings, conveying that through deep empathy, and then helping them feel safer and better prepared so they can once again focus on the child's needs. Cognitive reframing often occurs through these dialogs, but therapists who are trained in cognitive therapy can use various reframing techniques to help the parents, as well. This is done in a transparent, psychoeducational manner, as the therapist teaches parents the cognitive restructuring approach being used so they can apply it themselves as needed in the future.

HOME PLAY SESSION AND GENERALIZATION PHASE

After parents have mastered the play session skills and are able to watch for play patterns and themes, usually after four to six supervised play sessions, the therapist helps them transition to the home setting. During this phase, the parents hold weekly play sessions independently at home and meet with the therapist weekly or biweekly to discuss them. The skill feedback process and the play theme discussions remain much the same.

Shortly after the home play sessions are underway, the therapist helps parents generalize the play session skills for use in daily life. Because the parents have already mastered the skills, they are usually eager to use them more broadly and often have already done so. This stands in contrast to traditional parent training programs where parents learn about the skill in one session and are asked to try it at home. They often report back that they tried the skill and ''it didn't work.'' This is most likely because they had not yet mastered the skill, applied it in a too-complicated situation, or simply had unrealistic expectations that using it one time would fix their problems. Filial Therapy avoids this problem by asking parents to confine skill use to the play sessions at first. By the time the therapist suggests skill generalization, the parents are ready to apply the skills in the more complex home environment.

During each session in this phase of FT, the therapist and parents first review the home sessions that have occurred during the intervening period. The latter part of the session focuses on generalizing one skill at a time. The therapist then encourages parents to use that skill in a few different situations and to discuss it during the subsequent session. After parents learn to use empathic listening and limit setting as needed, the therapist shows them how to broaden the structuring skill. The structuring skill in play sessions is rather narrowly defined, whereas in daily life it expands to the process of anticipating problem areas and preventing them, often by altering the environment or antecedent conditions. Parents learn to resolve recurrent problems by looking at their origins and changing something in the situation. For example, if siblings tend to return home after school and immediately start bickering, parents can arrange for them to have a snack, separate and engage in different activities for a while, or involve them in a mutually interesting activity that encourages cooperation.

Finally, the therapist adds some parenting skills that are not used in the play sessions, including the appropriate use of reinforcement, parent I-messages, and how to prioritize the use of the various skills in different circumstances. L. Guerney's *Parenting: A Skills Training Manual* (1995) is very useful during this generalization phase. Therapy ends by mutual therapist-parent decision when the initial goals are met, the home filial play sessions are going smoothly, and the parents are using the skills as needed in their normal lives.

DOES FILIAL THERAPY REALLY WORK? THE RESEARCH

When FT was first introduced to the professional community, it was not received with open arms. Most likely, it was ahead of its time. The Guerneys and their colleagues immediately began researching it, countering the criticisms with evidence. Early research results and parent enthusiasm coupled with its unfriendly professional reception led to a grant from the National Institute of Mental Health in the 1970s to further research efforts. Since that time, the number of FT studies has been increasing dramatically.

A meta-analysis of play therapy and FT research (Bratton et al., 2005) demonstrated that parents in FT performed 1.06 standard deviations better than nontreatment controls. Parent involvement, especially Filial Therapy, showed strong advantages over individually administered play therapy, which was also shown to be effective.

The FT research has been reviewed elsewhere (briefly in VanFleet, 2005, and more extensively in VanFleet, Ryan, & Smith, 2005). Because research helped shape the development of FT from its earliest days, a strong and growing body of empirical validation exists. This evidence demonstrates its effectiveness and wide applicability. Consistent findings show improvements in child adjustment as well as in parental acceptance, skills, and satisfaction and decreases in presenting problems and parental stress. Furthermore, these gains have been maintained in three- and five-year follow-up studies. Its adaptability to other cultures has also been shown through research.

SUMMARY

Filial Therapy is a powerful family intervention with more than 40 years of clinical experience and research behind it. Interest in its use is growing worldwide, most likely because of its adaptability and effectiveness. Theoretically speaking, FT is a truly integrative model, incorporating methods from several orientations into a comprehensive psychoeducational approach. This contribution has explored the play therapy and cognitive behavioral therapy components of FT, which work together to enhance the lives of children, empower parents, and strengthen families. In closing, the voices of parents who have participated in Filial Therapy speak to its value:

- When my therapist first told me we would play with my daughter in order to solve the behavior problems, I couldn't believe it. Now I do. As we became closer and I understood more about what she was feeling, I was able to help her rather than yell at her.
- I thought my therapist was going to keep my kids from coming back to live with me. But he helped me do the play times, and they moved back a year ago. We're doing great, and the kids still keep asking me to have special play times, so we do.
- The best thing is that now I'm more playful myself. I was always worried about being in control, and Filial Therapy helped me see that this was part of the problem. I learned to play again, first from the therapist, but mostly from my kids. I still like control, and Filial didn't take that away from me—it just helped me mellow out so that I could enjoy my kids and my life MUCH more. Filial rocks.
- After I got out of rehab, my son was hospitalized. They told me it was my parenting. The last thing I needed was more therapy. I think it was our third filial play session when my boy first invited me to play with him (in a role). Later, when the therapist helped me realize how much he enjoyed playing with me, I broke down. I couldn't believe that anyone could need me like that. From that moment on, it has helped me stay sober and to be the kind of mom that he needs.
- I nearly gave up hope with our adopted son. He was out of control, and we had to stand guard at night in case he got up and caused serious problems. Filial Therapy allowed us to help him work through all the horrible trauma that he had been through before we adopted him. It was tough work, but it felt good to be part of his healing in such an intimate way. We both learned to manage his rages

> and bad behaviors much more effectively, but it was the play sessions that really helped him calm down and find himself. It's been beautiful to see the transformation and to know that we had something to do with it.

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CHAPTER 14

Kinder Training: An Adlerian-Based Model to Enhance Teacher-Student Relationships

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> Concentration on school subjects is largely dependent upon the child's interest in his teacher
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> —Adler, 1930, p. 167

> An educator's most important task, one might almost say his holy duty, is to see to it that no child is discouraged at school, and that a child who enters school already discouraged regains his self-confidence through his school and his teacher.
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> —Ansbacher & Ansbacher, 1956, pp. 399–400

Ms. Green is a first-grade teacher. It is the week before Thanksgiving, and she can tell her students need a vacation. As she watches her students from her desk, she can tell she needs this upcoming break, too. Suddenly, a pencil flies across the room and a child shouts, ''Ms. Green, Antionette is being mean again!'' Ms. Green has had it. She shouts from her desk that Antionette is out of luck and will need to find some other class to be in for the rest of the day. The other kids start to chant, ''Antionette's in trouble, Antionette's in trouble!'' Antionette looks confused about what to do next. Ms. Green gruffly says, ''Go next door until I come get you.'' Antionette slowly makes her way to the door, knocking into other students the entire way and muttering how much she hates school under her breath.

Ms. Blue is also a first-grade teacher. She is aware that between standardized testing, an intense curriculum, and not a lot of time for kid stuff her class can use a relaxing Thanksgiving break, too. They have three more days to go, but her approach is a little different. She's walking around her room noticing what students are doing. Her students hear her saying, ''Angela, I see you're working on number eight, and Javier, you're on number 16.'' Both students look down at their paper and write a little more intensely. Next, she moves toward the back of the room, where she sees a student sitting with his arms crossed and a tear halfway through his math sheet. She squats down to his eye level and quietly says, ''Jacob, you're looking upset about something, but worksheets aren't for tearing. What can I do to help?'' The student says he isn't good at math. She sits down at his table and begins to help Jacob and the other students around him by noticing what they're working on and saying things like, ''It seems like this math is hard, but you're still trying.'' With each statement, she notices Jacob seems less likely to give in when his efforts and emotions are recognized in the classroom.

Dr. David Satcher (2001) stated in his forward to the *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* that ''Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions that were explicitly created to take care of them. Play therapy expert and child development advocate Dr. Garry Landreth (2002) believes that a warm, caring relationship between a child and adult is critical for healthy child development. For most children those critical relationships are with parents and teachers. The vignettes at the beginning of this chapter offer glimpses of the different ways teachers interact with students in their classrooms. Kinder Training provides an opportunity for teachers to talk about challenging behaviors and their cognitive and relational reactions to them and to learn new ways of relating with students that foster a healthy bond and support a climate for learning.

WHAT IS KINDER TRAINING?

''Kinder Training (initially called Kinder Therapy) is an effective teacher consultation model based on developmentally appropriate strategies for making positive connections between teachers and students'' (White, Flynt, & Jones, 1999, p. 380). When educators participate in Kinder

Training, they learn new ways to interact with their students individually and as a classroom group. However, utilization of the child-centered skills associated with Kinder Training requires a foundation for thinking about child development, classroom management, and what students need emotionally to be successful academically. In other words, before the educators can interact differently, they have to believe differently. Some teachers already work from the foundational beliefs that support this model; other teachers either incorporate new beliefs or make adjustments to their thinking during the training process. Either way, the teachers who feel most successful at the end of training often share that Kinder Training changed the way they think and behave in the classroom and that these changes led to positive changes in teacher-student relationships on an individual and classroom level.

Kinder Training History and Research

Early qualitative research on Kinder Training began with a case study in which one teacher was trained by the school counselor (White, Flynt, & Draper, 1997). This training was made easier by the fact that the teacher was already trained in the Adlerian concepts that support the model. This school counselor's program included school-wide training for teachers in positive classroom management skills that were all grounded in the Adlerian principles and interventions of encouragement, respect, logical consequences, understanding the child's mistaken goals, and how to respond to behavior related to mistaken goals. After a short training in the basic facilitative skills of play therapy, the counselor and the teacher worked together with a child from the teacher's classroom. Eventually, the teacher took the lead in the school's playroom, and the counselor served as a supportive coach and consultant. The teacher received supervision after each session. The most powerful results of this experience, according to the teacher, were that the child, who was in crisis, was able to develop a collaborative, peaceful relationship with her teacher and the teacher began to view this child through a more positive lens. The child was able to come to school and function well in her classroom.

As a result of the positive outcome of this case study and the very positive feedback from the teacher regarding her ability to transfer her new language and skills to the classroom, White and Draper, counselor educators, and Flynt, a professional school counselor, began their collaborative work to develop the Kinder Training model (to be covered in a later section of this chapter). As a result of advice from school leaders and school researchers at the district level who were concerned with using the words ''therapy'' in school-based counseling settings, White, Flynt, and Draper decided to change the name of the model from Kinder Therapy to Kinder Training. After the development of the Kinder Training Manual (White, Draper, Flynt, & Jones, 2000), other research began.

Draper, White, O'Shaughnessy, Flynt, and Jones (2001) used a mixed-method design to study the impact of formal, group Kinder Training, much like the Filial Therapy training model (Guerney, 1964), on the student-teacher relationship and on the students' social and academic behaviors. After two days of training and practice, 14 teachers engaged in six playroom practice sessions with a child from their class. Teachers chose children in their class with whom they were struggling to connect. Many of these students also struggled academically and socially with peers. After each session, teachers received supervision from a trainer. The group results indicated a decrease in problem behaviors and an increase in adaptive behaviors (as rated by teachers). The children also appeared to be more successful on social functioning and academic competence, again as rated by the teachers. Teachers also rated the students as more encouraged, which means that the students may be more likely to engage, take risks, and have an overall better self-concept related to learning and their classroom. Also, teachers' facilitative responses in the classroom increased. Results of academic measures indicated that students' literacy skills improved and their time engaged in academics increased. In the qualitative interviews with teachers, they shared how they were interacting differently with their students. These differences involved increases in their use of encouragement over praise, which fostered stronger, more respectful relationships with their students. They also noticed that they were thinking about their students in more holistic ways, which led to them to choose more effective interventions.

Draper, Siegel, White, Solis, and Mishna (in review) conducted a study in which parents and teachers of preschoolers were trained in Filial Therapy and Kinder Training respectively so that they could enhance their existing relationships with prekindergartners attending a lottery-funded prekindergarten program in public schools.

The basic premise of the study was that if existing relationships with significant adults could be strengthened, then these relationships might serve as a protective factor as these students matured and entered kindergarten. The content of the program included training and skill development in Kinder Training for teachers or Filial Therapy for parents. Parents were trained to conduct play sessions at home with their preschooler and met weekly in a group to discuss their progress. Teachers were trained to speak the ''language of play'' in the classroom via modeling and coaching provided by the researchers each week as the teachers practiced. Tracking, empathy, encouragement, and limit setting (TEEL) constitute the language of play, and they were the core skills of both parent and teacher training. Quantitative and qualitative results suggest that teachers perceived children who received the intervention as exhibiting less problematic behaviors than their counterparts who were in a wait-control group. Overall, parents who received the intervention thought it taught them new and useful skills and helped them feel closer to their child.

Solis (2005) conducted a qualitative study of Kinder Training from a treatment acceptability perspective. Teachers participated in pre- and post-Kinder Training interviews. Generally, the teachers in Solis' study found Kinder Training to be a reasonable and useful intervention.

Because of the success of Kinder Training, in 2006, Safe and Drug Free Schools in Gwinnett County, Georgia, created a new program titled, ''Behavior Recovery.'' Behavior Recovery is an effort in the schools aimed at helping students by providing Kinder Training for teachers and Filial Therapy for parents. Behavior Recovery is based on the best practices of fostering teacher/student and parent/child relationships. Nested in the larger Behavior Recovery study was a qualitative study by Edwards (2007) that focused on the treatment acceptability of Kinder Training with five teachers. The results indicated that the teachers perceived that Kinder Training improved their relationship with their target students and helped them develop and implement more effective classroom management skills.

Currently, White, Flynt, Wynne, Jones, and Eberts are conducting another Behavior Recovery study that spans three elementary schools in the same school district. This study is again funded by Safe and Drug Free Schools as a part of their second ''Behavior Recovery'' effort. Data collected in this study will add to what is known about implementing Kinder Training on a larger scale and offer insights about its impact on students who receive special education services.

THEORETICAL FOUNDATIONS OF KINDER TRAINING

Kinder Training is grounded in universally held principles that support the importance of play for healthy child development and Adlerian psychology (Individual Psychology) (Ansbacher & Ansbacher, 1956). Combining play principles and language with Adlerian concepts and techniques provides a consistently effective approach for teachers to use when relating to their students and managing their classrooms.

IMPORTANCE OF PLAY

Play is critical to the healthy development of all children. It is through play that a child can truly communicate. It is also through play that an adult can understand the real child not the child who is complying with adult demands. In his new book, famed child development specialist David Elkind (2007) stresses that children's play is essential for good physical and psychological health. He states, ''Play is not a luxury but rather a crucial dynamic of healthy physical, intellectual, and social-emotional development at all age levels'' (Elkind, 2007, p. 4). This is especially true for children.

Through free play children explore and process their daily lives through their natural inclination to play. In fact, children are compelled to play and only stop their play when adults intervene. For children, play is an activity that is not only pleasurable and ''intrinsically complete'' (Landreth, 2002, p. 7), but it also offers an opportunity to use toys to master skills and access emotions. Through trial and error and the manipulation of materials, children practice the skills that they need for learning and healthy socialization. Children who are fortunate enough to have the freedom to play are able to tap into their innate creativity, take risks, and develop a healthy sense of self. Children who are deprived of free play and forced into adult-directed play are less able to think creatively and to feel capable. Adult-directed play rests on the idea that adults evaluate children's play, taking away their opportunity to make meaning of the world in which they live. Therefore, in order to develop meaningful relationships with children, adults must make every effort to understand and interact with them in developmentally appropriate ways. We believe play is the most developmentally appropriate way to connect with a child.

OVERVIEW OF INDIVIDUAL PSYCHOLOGY

The Kinder Training Model is theoretically grounded in Alfred Adler's Individual Psychology. Throughout his career, Adler (1930) emphasized the importance of educational environments that encourage social connection, cooperation, and respect. Individual Psychology takes a systemic view of people as social beings in that they cannot be considered in the absence of the context in which they interact. For a child, this starts with the family and extends to school, peer, societal, and other contexts in which the child is relating in some way to other people. Adult conceptualizations might include additional contexts, such as work or romantic relationships. Within these contexts, individuals are striving to feel important and significant. This sense of belonging or lack of it contributes to a person's level of encouragement or discouragement accordingly. The intensity of encouragement or discouragement experienced by a person is rooted in the person's perception of their importance or significance within these contexts. The perceived sense of belonging highlights the strong influence of cognitions on subsequent feelings and behaviors. Adlerian conceptualizations consider a person's thoughts, feelings, and behaviors within their social system. This holistic approach to thinking about human behavior provides an opportunity for clinicians or, in the case of Kinder Training, educators to make tentative hypotheses about children and develop a plan for how to enhance a student's (or an entire classroom of students') social interest (Ansbacher & Ansbacher, 1956).

Adler defines social interest as ''the individual's awareness of belonging in the human community and the extent of his or her sense of being a fellow being'' (Griffith & Powers, 1984, p. 7). Social interest, often considered a measure of mental health, can be seen in classroom behavior that shows a willingness to learn in cooperative ways.

ADLERIAN PRINCIPLES RELATED TO KINDER TRAINING—COGNITIVE ASPECTS

Kinder Training is about helping teachers develop beliefs and use interpersonal skills that will create a learning environment that supports students' development of social interest and learning. Kinder Training is based the following core beliefs of Individual Psychology:

> *People are socially embedded* (Dewey, 1978). Throughout the training, educators are asked to consider the context in which a challenging student behavior occurs. In this way, children cannot be understood without considering the social systems to which they belong. Explorations of a student's primary familial context are a focus, but the impact of the classroom context is considered as well. Learning how to utilize information about the groups to which a student belongs provides valuable information educators can use to conceptualize student behaviors and levels of social interest, which is critical to success in the classroom.
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> *People are self-determining* (Dewey, 1978). This concept addresses the fact that students do not merely react within their family, peer group, or classroom. People, even very young ones, are constantly making choices about how to respond in different situations. This optimistic principle about a person's innate ability to find ways to cope provides the potential for change. Really discouraged teachers are often encouraged by learning that a discouraged student might eventually use more socially appropriate coping strategies in the classroom context. This mind-set in the teacher often encourages them to try out new ways of responding to a situation that enables students to respond differently.

> *People are goal directed* (Dewey, 1978). Misbehavior is a purposeful endeavor. When a student gets out of her seat while the teacher is talking, she has a goal she is trying to achieve. It could be to pick up a pencil that rolled off her desk or to garner attention or power in the classroom. The purpose or goal of behavior is often easily determined by exploring how the teacher feels in response to the student's behavior. When teachers start thinking about student behavior differently, they often change their approach to managing the classroom environment. New teacher behaviors have a subsequent impact on student thoughts, feelings, and behaviors.
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> *People view life subjectively* (Dewey, 1978). Student perception is student reality. Teacher perception is teacher reality. Several members of the same class will view the same situation through their own, unique lens. Children develop their unique way of viewing the world through their interpretations of early childhood experiences. These interpretations affect the child's feelings of belonging or discouragement and level of social interest. Helping teachers learn how to make guesses about how the child views himself or herself, others, and the world often increases empathy and provides clues for how the child thinks and feels and the purpose of his or her behaviors.
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> *People are holistic beings* (Dewey, 1978). From this perspective, a teacher plus a student interacting do not equal two people interacting. Each brings their parents, siblings, previous school experiences, previous nonschool experiences, and thoughts about themselves, others, and the world around them with them to the meeting. Even though it sounds like a lot to manage, teachers who participate in Kinder Training come to realize the myriad of influences that impact their students' thinking, feeling, and behaving. This awareness helps them look for patterns of student behavior in the classroom that are ineffective and find ways to help children shift to different means of belonging.

When educators are able to utilize these principles to conceptualize student behavior, they are able to understand their students in more hopeful and helpful ways. Having a way of understanding the goals of student behavior encourages educators to make different choices in how they intervene in difficult classroom situations.

ADLERIAN PRINCIPLES RELATED TO KINDER TRAINING—BEHAVIORAL ASPECTS

From an Adlerian standpoint, perceptions of belonging and discouragement can have a deleterious impact on student behavior and learning (Brigman, Mullis, Webb, & White, 2005). These behaviors, or coping styles, are purposeful and can run along a continuum from slightly disruptive to severely disruptive to student learning. At times, discouraged students who desperately want to feel important and significant in the classroom will utilize a mistaken goal of behavior as a means of relating in some way and getting a need met.

Rudolf Dreikurs, Adler's famous student and colleague, continued to explore how discouraged children often work very hard to get their needs met. He described that ''. . . a misbehaving child is only a discouraged child trying to find his place'' (Dreikurs & Cassel, 1972, p. 32). Dreikers and Soltz (1964) identified four mistaken goals of behavior that fall on continuums of discouragement and social interest.

Mistaken Goal of Attention. The least discouraged, most socially interested mistaken goal is attention. When children are seeking attention they are saying, ''I only count if people notice me.'' Children can actively or passively and constructively or destructively seek attention in the classroom. An active-constructive attention-seeker might find their significance in the classroom by being the ever-reliable kid who always has his hand up with the right answer. An active-destructive attention-seeker might try to fit in by clowning around for lots of laughs during a reading group. Passive-constructive attention-seekers can come across as model classroom citizens who always have their materials in place and a smile on their face. Passive-destructive attention-seekers might appear shy or lazy even if they know what to say or do but want to hear a little coaxing. For a time, most teachers can tolerate most of these behaviors. Over time, adults begin to feel annoyed by having to give this group of children the special attention they are demanding through their behaviors.

Mistaken Goal of Power. The second mistaken goal of behavior is power. The students in this more challenging, less socially interested, more discouraged group believe ''I only count when I am in charge or have the power.'' When you think about teachers as leaders of the classroom, it is easy to understand how this mind-set can clash in the learning environment. The mistaken goal of power can be passive or active, but it is always destructive in a social setting. Passive-destructive power-seekers come across as stubborn, giving off the air that ''I will or won't if I do or don't want to.'' This tends to create chaos when teachers have to teach curriculum and move through lessons to get students ready for standardized tests. Active-destructive power-seekers often look like rebels with a cause who desperately look for power by arguing, contradicting, or having tantrums. These students can use up a lot of instructional time trying to run the classroom, which makes their teachers feel incredibly angry.

Mistaken Goal of Revenge. Revenge-seekers believe ''I only count if I can hurt others as I have been hurt.'' As one can see, children who seek revenge show an even greater deficit of social interest and higher levels of discouragement. Passive-destructive revenge-seekers sit low in their seats, but the sullen faces are very apparent and speak volumes. Active-destructive revenge-seekers choose behaviors that hurt other students and teachers and actually try to drive people away. They are often successful, leaving a wake of hurt feelings throughout the classroom. Teachers often feel attacked and want to retaliate when students interact in this way.

Mistaken Goal of Withdrawal. The final goal is also known as ''display of inadequacy.'' This deeply discouraged and socially disinterested student thinks ''I don't count at all.'' These students show a passive-destructive pattern of relating that says, ''I feel stupid, incapable, and insignificant.'' Teachers often try very hard to connect with and want to help this group of students, yet they often feel hopeless about how to do that. This student is often so discouraged that they completely withdraw from the learning environment, which sets the student up for further social isolation and possible grade retention.

Dreikurs and Cassel (1972) describe how well-intentioned adults often mistakenly encourage difficult behaviors in how they respond to children. When children feel ignored, overpowered, hurt, or abandoned by the important adults in their lives, behaviors escalate, social interest wanes, and discouragement grows. Lew and Bettner (1995) write about the teacher's role in understanding and motivating children. They believe that for students to take risks to learn in the classroom, they need to feel capable, connected, like they count and possess courage. These feelings are strongly impacted by what the teacher thinks about children and child behavior and the behaviors he or she chooses to create in a classroom climate that encourages connection and a willingness to try new things. Kinder Training offers educators an array of behaviors that can build stronger connections, de-escalate troubling classroom behaviors, and foster a climate for trying and learning.

THE KINDER TRAINING MODEL

Teacher-student relationships can often be strained if they are based on authoritarian methods. Teachers often resort to hard-line, authoritarian classroom management when they feel out of control. This is often due to a lack of training in teacher education training programs regarding the social/emotional well-being of students and effective classroom management. The development of Kinder Training is a direct result of the school counselors' felt need to help their teachers relate to students in ways that do not result in anger and frustration. As with parent-child relationships developed through Filial Therapy training, student-teacher relationships can be respectful, encouraging, and enjoyable for both.

Kinder Training (White, Draper, & Flynt, 2003) has evolved into a powerful and sustainable consultation model that includes:

1. Didactic group training for teachers,
2. Practice with one another followed by supervision,
3. Weekly, individual play sessions with an identified child followed by supervision, and
4. Classroom coaching to transfer and sustain the therapeutic language and the Adlerian principles for classroom management purposes.

The following is an overview of the content and process of Kinder Training. This training model can be seen in even more detail in the Kinder Training Manual for trainers (White et al., 2000).

TWO-DAY TRAINING

The two-day training incorporates didactic and experiential learning opportunities. The first day of didactic group training for teachers consists of:

1. Icebreakers, energizers, and introductions,
2. Overview of the purpose of Kinder Training including a discussion related to choosing a student to work with on a weekly basis in the playroom,
3. Introduction to the importance of play for children,
4. Discussion of their concerns regarding their students' development and success in the classroom,
5. Introduction and review of critical issues of normal child development and how they relate to free play,
6. Play therapy language training (TEEL: Tracking, Empathy, Encouragement, Limit Setting),
7. Processing of video examples of the use of TEEL,
8. Introduction to Adlerian Psychology principles for enhancing classroom management that includes overviews of encouragement, empathy, understanding family atmosphere, lifestyle development and psychological birth order, the role of mistaken goals of behavior and what they look like in the classroom, logical consequences, and limit setting,

9. Processing of videotaped case examples of Adlerian Psychology principles, and
10. Wrap up for the day including feedback and preparation for the second day of training.

In addition to the training, teachers receive a comprehensive notebook that includes supporting resources, such as handouts and other pertinent reading materials, to use throughout the day and subsequent weeks of training.

The second full day of Kinder Training is more experiential in nature:

1. The day begins with review of and reactions to Day One information.
2. Teachers pair up to go into the playroom to practice using TEEL. One teacher role-plays the child that he or she will be working with while the other teacher practices the skills. Teachers are also encouraged to avoid leading the play and labeling the toys. For information about toy selection and arrangement, see Landreth (2002).
3. Each practice session is observed by at least one of the trainers and the teachers who are participating in the training.
4. After each practice session, the teacher receives immediate verbal and written feedback from their trainer and the other teachers who observed the session.
5. In order for everyone to receive a satisfactory amount of practice and feedback, it is ideal to have at least two small groups (or more) of teachers working simultaneously with their own trainer. Portable playroom kits can be used in lieu of a traditional playroom when using the multiple groups practice format.
6. The last hour of Day Two is spent creating a schedule for weekly playroom sessions for each teacher, child, and supervisor group. Obviously, in a school setting, time is of the essence, and the teachers' schedules are rigid. In cases where the teacher does not have paraprofessional support in the classroom, the school counselor can plan classroom guidance during the time to enable the teacher to be in the playroom with their student and supervisor. Each teacher leaves with a parent permission form that must be returned with a signature before the play sessions can begin.

WEEKLY PLAY SESSIONS AND SUPERVISION

After the two-day training ends and parent permission is obtained, each teacher begins individual play sessions with his or her identified student.

During the first session, the trainer stays in the playroom with the teacher and the student. When the trainer is present, he or she is able to supportively coach the teacher as he or she begins to use the TEEL language in the playroom. During the five (can be more if possible or necessary) subsequent weekly sessions, the trainer observes the teacher/child play session via live video. After each session, the student returns to the classroom, and the trainer and teacher meet for 10 to 15 minutes of supervision. Written feedback is provided and teachers are encouraged to watch their playroom session videos to prepare for upcoming sessions.

Classroom Coaching

Toward the end of the playroom visit supervision sessions, the trainers begin to encourage the teachers to think about times when they could use the Adlerian concepts and TEEL language in their classroom. For example, teachers might be encouraged to track students while they work on in-class assignments or use empathy statements when students show emotion in the classroom. Teachers can also begin to encourage appropriate school-based behaviors by saying, ''You're working hard to walk quietly in the hallway,'' which is a type of encouragement. This initial brainstorming helps teachers start transitioning the skills they learned in Kinder Training from the playroom to the classroom.

After a teacher finishes the six playroom sessions with his/her student, the trainer visits the classroom six times to observe and offer feedback as the teacher applies the TEEL language and Adlerian concepts in the classroom environment. It is helpful at first if teachers can either watch a video of what this looks like in a classroom or if the trainer can model the skills in the teacher's classroom. With this vision in mind, most teachers are able to transfer the skills into a different environment with relative ease. In some cases when teachers struggle with using the skills in the classroom, the trainer can serve as a coach who can model, whisper in the teacher's ear, or write down suggestions for how the teacher can respond to different student behaviors. Feedback from teachers indicates that classroom coaching is valuable and necessary for the transition to the classroom.

With each Kinder Training research project, the developers and trainers have learned that it is vital to follow up with the teachers and administrators to work through school-specific concerns and needs and ensure that teachers are able to continue using the playroom as a helpful intervention that supports healthy teacher-student relationships, social and emotional growth, and student achievement.

Kinder Training is a method of consultation that empowers educators to connect with students in a manner that encourages personal development and academic achievement. It is grounded in principles from Individual Psychology and gets its wings from the Guerneys' work in Filial Therapy. Kinder Training helps educators develop new ideas about how to conceptualize students and learn and use communication skills that can enhance the student-teacher relationship. Within the context of this different relationship, students begin to think about themselves differently, feel more encouraged and connected in the classroom, and find new, more appropriate ways to belong to and learn in their classroom.

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CHAPTER 15

Sandtray Therapy

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SANDTRAY THERAPY IS an expressive therapy with significant flexibility. It can be used with clients of all ages, it can be nondirective and directive, and can be fully nonverbal and projective while also being cognitive and solution-focused. This chapter will explore these variable applications, including a consideration of sandtray as a trauma intervention and a brief look at the sandtray therapy literature.

Homeyer and Sweeney (1998) define sandtray therapy as ''an expressive and projective mode of psychotherapy involving the unfolding and processing of intra- and interpersonal issues through the use of specific sandtray materials as a nonverbal medium of communication, led by the client(s) and facilitated by a trained therapist'' (p. 6). The therapeutic use of sand in a tray, with a collection of miniatures and availability of water has been used in a variety of ways since its inception.

The tools of the sandtray therapist are simple. First, there is *sand and water*, which are basic elements of the Earth, naturally and kinesthetically appealing. Then there is a *tray*, a container for not only the sand and play media, but also a container of the client's psyche. Finally, there is the *collection of miniatures*, which serves as a universe of symbols and images and more specifically the ''words'' that the client can present in therapy without having to directly verbalize painful issues. It is important to note that these are tools for the therapist; however, it is the sandtray process and product that create a milieu in which clients can approach and work through turmoil and trauma.

BRIEF HISTORY OF SANDTRAY THERAPY

In the 1920s, Margaret Lowenfeld (1979) was looking for a way to connect with her child patients in an honest way, without contaminating the child's communication with adult perceptions, perspectives, or preconceived theories. While Lowenfeld served as a physician during the Russo-Polish War, the horrors and impact of war on the troops, prisoners of war, displaced students, children, and families had a profound influence on her. When she began working with children in 1925 she explored interventions through which children could communicate their perception of their world. Lowenfeld sought ''to find a medium which would in itself be instantly attractive to children and which would give them and the observer a 'language', as it were, through which communication could be easily established'' (p. 281).

Lowenfeld recalled a book she'd read, *Floor Games*, by H. G. Wells (1911). In the book Wells shares detailed, lengthy, and involved stories about how he and his sons would play with small toys on the floor of his home. Seeing the application to her work with children, Lowenfeld began collecting miniature toys, and offered children a chance to share their worlds with her. This developing intervention came to be called ''The World Technique.''

While others began to employ Lowenfeld's techniques, the next major boost to the use of sandtray therapy was Dora Kalff. Kalff, a Jungian-trained therapist, having spent some six years at the Jung Institute, attended a psychiatric conference where she heard Lowenfeld present her World Technique (Weinrib, 1983). In 1935, Kalff went to London and studied with Lowenfeld, returned to her native Switzerland and developed the Jungian approach to sandtray therapy, which she termed ''Sandplay'' (Kalff, 1980). Kalff had been strongly influenced by Jung's mentoring and her experience with Eastern mysticism while living in the Far East. Another sandplay expert of note is Jungian analyst John Allan. His practice and writings (Allan, 1988) have influenced Jungian child therapists of the current generation.

An important distinction needs to be made here. The term *sandplay* is often used to describe any psychotherapeutic use of the sandtray and miniatures. The term sandplay, however, specifically applies to the Jungian approach to sandtray therapy. While the approaches of Lowenfeld and Kalff remain the primary approaches to the therapeutic use of the sandtray, there are other orientations which have been developed over the past several decades.

Oaklander (1988) employs a Gestalt approach to working with clients in the sandtray. She posits that sand and play therapy interventions assist in the formulation of the *I/Thou* relationship, a key concept in Gestalt therapy (Oaklander, 1994). Additionally, as an approach focused on process, Gestalt sandtray therapy enables clients to process contact-boundary disturbances and create the sense of self that may have been damaged, as well as promoting awareness and addressing resistance (1994).

Another contributor to sandtray training and writing is Gisela Schubach DeDomenico (1995, 1999), who developed an approach called Sandtray-Worldplay. Her initial research was with normal preschool children in nondirective sandtray. The children worked in individual trays in a group setting, and she discovered the preschoolers could work two to four hours, evolving through a series of worlds. She works extensively with sandtray in individual and group settings, with clients working in parallel, joint, and communal play. A proponent of group sandtray, DeDomenico (1999) indicates that groups provide clients with the opportunity to develop the ''ability and interest to create communally'' (p. 220), and that the group sandtray experience can ''overshadow the individual's separate identity . . . sandtray becomes a true mirror of the group psyche and what community is really about'' (p. 220).

RATIONALE FOR THE USE OF SANDTRAY THERAPY

The fundamental purpose for using sandtray therapy is to provide a nonverbal method of processing issues for clients presenting with a variety of issues. Homeyer and Sweeney (1998, 2005) detail multiple rationale for the use of sandtray therapy:

Sandtray therapy gives expression to nonverbalized emotional issues. Since play is the language of childhood, as well as a language for clients of any age who are unable or unwilling to verbalize, the sandtray provides a safe medium for expression. If sandtray is the language, then the miniatures are the words. Just as an empty canvas provides a place for the artist's expression, so the tray provides a place for the client's emotional expression. The client needs no creative or artistic ability since the medium provides a flow that is free from evaluation.

The self-directed sandtray process allows clients to be fully themselves. This can create opportunities for directed sandtray experiences. Through the process of sandtray therapy, which includes a caring and accepting relationship, children and families can express their total personality. This enables hurting clients to consider new possibilities (therefore a strengths-based modality), some of which are not possible through verbal expression, and thus significantly develop the expression of self. Sandtray therapy is, therefore, more than a symbolization of the psyche; it is a forum for full self-expression and self-exploration.

Sandtray therapy has a unique kinesthetic quality. Sandtray therapy provides a sensory experience and meets the need that we all (not just our clients) have for kinesthetic experiences. This fundamental essential, an extension of foundational attachment needs, is met through relationship and experience. Sandtray therapy provides both of these elements for clients.

The very tactile experience of touching and manipulating the sand is a therapeutic experience in and of itself. We have frequently had nonverbal clients who have done nothing more than run their fingers through the sand and then begin to talk about deep issues. It seems like the simple sensory experience with the sand causes a loosening of the tongue. The manipulation of the sand and placement of the miniatures is both safe and kinesthetically satisfying, especially for clients whose prior sensory experience was negative or traumatic.

Sandtray therapy serves to create a necessary therapeutic distance for clients. Clients are often unable to express their pain in words, but they may well find expression through a projective medium such as sandtray therapy. It is often easier for traumatized clients to speak through one or more of the sandtray therapy miniatures than to directly verbalize their pain. The consistency of the medium, and the consistency of the therapist in allowing clients to direct the process, creates a place where clients can establish some degree of therapeutic distance. Clients of all ages, couples, families, and groups in sandtray therapy may experience emotional release through symbolization and sublimation, through the projection onto the tray and miniatures.

This therapeutic distance that sandtray therapy provides creates a safe place for abreaction to occur. All clients who have experienced trauma need a therapeutic setting in which to abreact, a place where repressed issues can emerge and be relived safely, as well as the opportunity to experience the negative emotions that are frequently connected. Abreaction, a crucial element in the treatment of trauma, finds facilitated expression.

Schaefer (1994) suggested several properties that provide the sense of distance and often reluctant safety that clients gain in sandtray therapy: (a) symbolization, for example, allows clients to use a predatory miniature to represent an abuser; (b) "as if" quality, where clients can use the pretend quality of sandtray therapy to act out events as if they are not real life; (c) projection, where clients can project intense emotions onto sandtray miniatures, who can then safely act out these feelings; and (d) displacement, where clients can displace negative feelings onto the miniatures rather than expressing them toward others, including family members. Sandtray therapy provides not only the opportunity for abreaction to occur, but it also facilitates the process through the setting and media.

Sandtray therapy with families is a truly inclusive experience. The typical adult talk therapy approach to treating families is decidedly exclusive, as it fails to recognize and honor the developmental level of children in the family. Sandtray therapy with families directly addresses this obstacle. Recognizing the need to address the lowest developmental denominator, sandtray therapy creates a level playing field for every family member, giving all persons the opportunity to express themselves.

Sandtray therapy naturally provides boundaries and limits, which promote safety for the client. Boundaries and limits define all relationships, most certainly the therapeutic relationship. The prescribed structure of the sandtray therapy process and the deliberately selected tools of the sandtray therapist provide clients with the boundaries that create the sense of safety needed for growth. The very size of the sand tray, the size and selection of miniatures, the office setting, and the facilitation of the therapist all provide boundaries and limits for clients. Although these limits are both important and intentional, they also promote freedom for expression. The implicit and explicit limits in sandtray therapy bring a focus to the therapeutic process, additionally promoting the safety which all boundaries bring, thus assisting clients to focus on the therapeutic issues to be addressed.

Sandtray therapy provides a unique setting for the emergence of therapeutic metaphors. While there is increasing literature discussing the benefits of metaphors in psychotherapy, much of it focuses on verbal metaphors. Siegelman (1990) suggested that metaphors ''combine the abstract and the concrete in a special way, enabling us to go from the known and the sensed to the unknown, and the symbolic. . . . They achieve this combination in a way that typically arises from and produces strong feelings that leads to integrating insight'' (p. ix). Metaphors can certainly be therapeutically powerful. We would suggest that the most powerful metaphors in therapy are those generated by the clients themselves. Sandtray therapy creates a unique setting for this to occur, as the sand and miniatures are ideal for clients to express their own therapeutic metaphors.

Where therapeutic metaphors emerge, therapists are often tempted to provide a therapeutic interpretation. We would echo Kalff's (1980) warning against focusing on interpretation, recognizing that it is the client's interpretation that is the most pertinent and therapeutic. We would further suggest that interpretation of sandtrays is not necessarily essential to the healing process, and therapists may need to remind themselves that when we interpret, we do so with our own minds and experiences, as opposed to the client's. It is a helpful reminder that, when interpreting a client's expression of an experience, the sharing of the interpretation is meant to serve the client's need and not the therapist's.

Sandtray therapy is effective in overcoming client resistance. Sandtray therapy, because of its nonthreatening and engaging qualities, can often captivate the involuntary client and draw in the reticent family member. Since play is the natural medium of communication for children, those who have been compelled into therapy by adults are generally more amenable to treatment because they are being allowed to express self through play.

For the resistant individual or family member, sandtray therapy can provide a means of communicating that diminishes the fear of verbal conflict. The level of contribution that family members make to the construction of the sand tray may be a reflection of their investment in the family. Additionally, resistance may not only be overcome by sandtray therapy, but more fully identified as well.

Sandtray therapy provides a needed and effective communication medium for the client with poor verbal skills. Beyond the developmental importance of providing children with a nonverbal and less abstract therapeutic medium, there are clients of all ages who may have poor verbal skills for a variety of reasons. This can include clients who experience developmental language delays or deficits, clients with social or relational difficulties, clients with physiological challenges, and more.

Just as young children who want something desperately but cannot communicate this to caregivers, so can anyone experience significant frustration when unable to effectively communicate needs. When toddlers have tantrums because they cannot communicate their wants or needs, there are pronounced relationship challenges between caregivers and children. Similarly, relationship challenges can emerge in families when people are unable (or unwilling) to verbalize their wants and needs. The sandtray therapy process creates a place where expression of needs and wants is not dependent upon verbalization. Clients with poor verbal skills, regardless of the etiology, find a place of relief in sandtray therapy—a place where expression does not depend upon verbal ability, but through the freedom of the medium.

Conversely, sandtray therapy cuts through verbalization used as a defense. For children who seem pseudo-mature and present as verbally astute yet are developmentally unable to effectively communicate on a cognitive level, sandtray therapy provides a means to communicate through their true and natural medium of communication. For the verbally sophisticated adolescent or adult, who use intellectualization and rationalization as a defense, sandtray therapy can cut through these defenses. This is an important systemic dynamic to be aware of, since a family may include a verbally well-defended member, as well as one or more members unable to establish effective communication and relationship. The nonverbal and expressive nature of sandtray therapy identifies this dynamic and provides a nonverbal way to address it.

Sandtray therapy creates a place for the child client or family to experience control. One primary result of crisis and trauma is a loss of control for people. The loss of emotional, psychological, and even physiological control is one of the most distressing byproducts of trauma and conflict. Individuals and families in crisis often feel the frustration and fear of having lost control. An important treatment goal for these clients should be to empower them, following any traumatizing experience that has been disempowering.

The self-directed process of sandtray therapy creates opportunities for control to be returned to clients. For clients attempting to attain and retain self-control, sandtray therapy establishes boundaries, which promotes the freedom for this to occur. For clients attempting to avoid responsibility, the sandtray therapy process places the responsibility for and control of the process on clients. If a goal of therapy is to help clients achieve a greater internal locus of control, sandtray therapy can be an effective means toward this end.

The challenge of transference may be effectively addressed through sandtray therapy. The presence of an expressive medium helps to create an alternative object of transference. Lowenfeld (1979) proposed that in the creation of worlds in the sand, transference occurred between the client and the tray, rather than between client and therapist. Weinrib (1983) noted that the sandtray often becomes an independent object, so that clients take away images of the tray rather than the therapist. Regardless of the theoretical perspective on transference, however, sandtray therapy provides a means for transference issues to be safely addressed as needed. The tray and miniatures frequently become the objects of transference, or the means by which transference issues are safely addressed.

Finally, deeper intrapsychic issues are arguably accessed more thoroughly and more rapidly through sandtray therapy. Accessing underlying emotional issues and unconscious conflicts presents a challenge in all therapeutic situations. We would suggest that the qualities of sandtray therapy, which have been noted above, generate an atmosphere where deep and complex intrapsychic issues can be safely approached.

It is hoped that most clients have a degree of motivation to change, perhaps only reflected by their presence in psychotherapy. Many of these clients are well-defended when confronting challenges to their egos, which have already been injured. Sandtray therapy can serve to decrease ego controls and other defense mechanisms, thus fostering greater levels of disclosure. This in turn creates an increased capacity to consider interpersonal and intrapersonal alternatives.

GENERAL PROCESS OF SANDTRAY THERAPY

Sandtray therapy, like any other therapeutic intervention, should be used in a thoughtful, purposeful, and intentional manner within the ongoing therapeutic milieu. Sandtray therapy can be utilized in individual therapy (children, adolescents, or adults), couples counseling, family therapy, and group therapy. It can be used as the primary mode of counseling, as a change of pace, or as a way of noting change and therapeutic progress.

Homeyer and Sweeney (1998, 2005) discuss an eclectic approach to sandtray therapy. The following is a brief summary, which begins with a discussion of the necessary equipment.

The media used in sandtray therapy can be quite basic or exceptionally elaborate and detailed. It is certainly not essential, however, to invest a great deal of expense or even office space in the development of an adequate collection of sandtray miniatures. An elaborate setup may in fact be overwhelming for some clients, and sometimes serves to meet the needs of therapists more than clients. The basic materials needed include two sand trays and a selection of miniatures.

The sandtrays themselves are usually 20 inches wide, 30 inches long, and three inches deep, painted blue on the inside to simulate sky and water, and are half filled with quality sand. Although inexpensive, it may not be best to use playground sand, which often contains small pebbles, or sand that is too fine, which can result in powder and cause allergic reactions. The size of the tray is important, as it naturally provides boundaries and limits for clients, and so that the product of a sandtray session can be viewed in a single glance. Two trays are preferable, and should be waterproof, so that one can be used for wet sand and the other dry. The tray(s) should be set on a stable surface, preferably a table about average desk height, with room around the base of the tray. Some clients like to position miniatures outside of the tray, perhaps representing intrapsychic issues which are not ready to be fully approached and processed. Additionally, it may be helpful to store tray(s) on a mobile cart which can be moved from the corner of the therapy room to the middle so clients can work with it.

A selection of miniatures is made available for use in the sandtray. It is generally suggested that miniatures be two to three inches in height. They should be selected exclusively for the sandtray therapy process—not collected. Again, thousands of miniatures are not necessary (and may in fact be emotionally flooding for some clients), but it is helpful to offer a wide assortment of toys and objects. Some basic categories include the following:

- Buildings (houses, castles, factories, schools, churches, stores)
- People (various racial/ethnic groups, military, cowboys, sports figures, fantasy, mythological, various occupations)
- Vehicles (cars, trucks, planes, boats, emergency vehicles, farm equipment, military vehicles)
- Animals (domestic, farm, zoo, wild, marine, prehistoric)
- Vegetation (trees, shrubs, plants)
- Deities (both Western and Eastern religions)
- Structures (fences, bridges, gates, highway signs)
- Natural objects (rocks, shells, driftwood, feathers)
- Miscellaneous (jewelry, wishing well, treasure chest)

Sensitivity to issues of diversity should be a priority in the selection of miniatures. Primarily, it is important to have miniature people (of both genders) reflecting a variety of ethnocultural groups. Using sandtray therapy in a predominately Latino community with a miniature collection containing only Caucasian figures would be fundamentally inappropriate. Another sensitivity issue is geographical consistency, for example, it is better to have miniature cactuses when working in a desert community and pine trees when working in the forest town.

Miniatures should be grouped together by category, and preferably displayed on open shelves. Although other displays are possible, clients are simply less likely to rummage through drawers or bins than they are to select objects from a shelf. Consideration should also be given to the setup of the miniatures, as the emotionally fragile client is less likely to select a kitten set right next to a fire-breathing dragon. Additionally, the impatient or reticent client may be less willing to search through a disorganized shelf. A counseling office used for several purposes might necessitate a covered bookcase to hold miniatures, so they will not be a distraction when not in use.

Homeyer and Sweeney (1998) describe six phases of the sandtray therapy process: (a) preparation of the sandtray setting; (b) introduction of the process to the client; (c) creation of the sandtray; (d) postcreation phase; (e) sandtray cleanup; and (f) documentation of the session.

Preparation of the sandtray setting is a simple but important part of the therapy process. The therapist should ensure that the sandtray(s) and miniatures are in place. This would include checking to see that no miniatures are still buried in the sand from a previous session and leaving the sandtray surface relatively flat and smooth. Furniture should be arranged so that clients have easy access to the materials, and the therapist should sit in a nonintrusive place in the room.

The introduction of the sandtray process may be directive or nondirective, depending on the therapeutic intent. The client can be invited to create a world (or scene/picture) in the tray using the miniatures, or can be directed to make a specific scene around an event or emotion in the client's life or on a general or specific theme. Further directive applications will be discussed below.

The creation of the tray, especially in the early stages of sandtray therapy, is generally left entirely up to the client. The therapist may do a number of things during the creation phase. This may involve making very few or no verbalizations to the client and providing complete nonverbal attendance to the client's work. The therapist may choose to ask questions about the scene as it is unfolding, or may simply reflect the content of the building process much as a child-centered play therapist might do.

Some sandtray therapists prefer to let the creative process stand alone. This may be left to therapist's judgment, or a reflection of the theoretical orientation to sandtray therapy. While this is valuable, we believe that the process needs to be interactive and involve greater discussion. Thus, the creation frequently serves as a springboard for discussion with the client.

The postcreation phase is a key aspect of the sandtray therapy process. Regardless of the initial instructions given to the client, it is still appropriate and often necessary to discuss the tray with clients. Generally, clients are asked to give a title to the tray and give an explanation to the contents. As with narrative approaches to therapy, it is considered important for clients to tell their story, and the sandtray provides a projective and expressive means through which to do this. Clients may be asked to describe the entire scene or portions of it or to discuss specific miniatures. They may be asked whether or not they are themselves represented in the tray or any other specific person, and they are often asked what miniature(s) have the greatest power in the tray.

Clients may be asked about what would happen if the scene were to continue or what happened previously. It may be helpful to frame the process as a client making a movie, and the tray represents the pause button being pushed on an action sequence. This creates the opportunity to dialog about future and preceding events, or it allows the tray to stand with minimal discussion.

It is important for sandtray therapists to consider several things in the evaluation of client sandtrays. This includes an evaluation of the creative process itself, the sandtray's contents, the client's story, and the therapist's own affective response to the tray. We would repeat the caution against being too interpretive, stressing the importance of the clients' own interpretation of the therapeutic metaphors in their own creation.

The sandtray cleanup may be done as a part of the session or after the client has left. This is generally left up to the client. Since the tray represents an expression of the client's own emotional world, therapists are advised not to clean that world up without the client's direction and approval. It may also be helpful to remind some clients that the tray and miniatures are used by others, and as such their tray cannot be preserved until the next session.

Documentation of the session should include the routine development of client progress notes, but should also include a photograph or sketch of the client's tray. This provides a visual and chronological record of the therapy process, which can be shared with clients to facilitate discussion and progress review. Homeyer and Sweeney (1998) include sandtray therapy session chart formats in their text.

TRAUMA AND SANDTRAY THERAPY

Although not a primary focus of this chapter, it is important to note that expressive therapies such as sandtray therapy may be crucial in the treatment of trauma. Psychic trauma eventuates in significant neurological activity and potential damage. There is an increased neurotransmitter activity, generating greater sympathetic nervous system activity. There may be decreased levels of corticosteroids and serotonin, the most pronounced effect likely being the diminished ability to moderate the neurotransmitter-triggered fight or flight response. Chronic exposure to traumatic stress affects the adaptation of many neurochemicals, which can significantly alter how people deal with their environment.

A specific example of this neurobiological effect of trauma might be seen in limbic system activity (e.g., the amygdala and hippocampus). The amygdala, which readies the body for action, may get hijacked by these neurobiological changes, and the trauma victim responds before the thinking part of the brain (i.e., cerebral cortex) can weigh threats. This can happen in daily life, as well as the counseling room.

Additionally, people with PTSD may experience a deactivation of the prefrontal cortex (which is responsible for executive function), further interfering with their ability to measure and respond to threats. This not only makes navigating posttrauma life difficult, but also interferes with the therapeutic process. High levels of emotional and physiological arousal are occurring, but the ability to process these is hampered. As van der Kolk (2002) notes, ''Trauma by definition involves speechless terror: patients often are simply unable to put what they feel into words and are left with intense emotions simply without being able to articulate what is going on'' (p. 150). A neuroimaging study (Rauch et. al, 1996) demonstrated this, showing that when PTSD clients relive their traumatic experiences (which is what they are asked to do in therapy), there is decreased activity in the Broca's area of the brain, which is related to language. At the same time, there is increased activity in the limbic system. When traumatized people are reliving their trauma, they have great difficulty verbalizing these experiences.

While this is happening, many therapists demand that clients verbalize the horrible events that they have experienced. Sandtray therapy does not follow this potentially damaging path. If therapists focus primarily on the emotionally charged content of the trauma, a client's fundamental physiological state can shift. Perry (2006) suggests that this shift may lead to the client and the therapy becoming brainstem driven. The resultant anxiety, in addition to the possible diminished functioning of the Broca's area, leads clients to act in a primitive manner. This renders the verbal language of therapy less accessible or perhaps useless. Words, however many, do not get translated into changes in the midbrain or the brain stem (Perry, 2006).

The implications for therapy seem obvious. Sandtray therapy offers clients a way to express trauma that does not force them to verbally express material that is not only difficult to talk about, but also neurologically inhibiting. Traditional verbal therapy may well be ineffective and perhaps detrimental. As clients experience the safety of the therapeutic distance of sandtray therapy, therapists can move to be more directive and cognitive in their interventions. Sandtray provides many opportunities to make this transition.

ADAPTATION OF COGNITIVE BEHAVIORAL TECHNIQUES TO SANDTRAY THERAPY

While the primary initial focus of sandtray therapy from the authors' perspective is to create a safe place for psychological and neurotraumatic issues to be addressed in a nonthreatening milieu, it is often helpful to use the method to advance client insight and provide a context for psychoeducational work. This must always be done in light of the client's developmental (not chronological) age. Although Rational Emotive Behavior Therapy (REBT) is not often associated with children, Bernard, Ellis, and Terjesen (2006) comment that ''REBT has historically recognized the importance of the young person's cognitive developmental level of maturity in treatment'' (p. 9). Waters and Craske (2005) remind CBT users: ''. . . factors such as the degree of impairment experienced by the child, developmental level, and the degree of parental anxiety or psychopathology all warrant consideration and may effect the outcome of the child's treatment'' (p. 109).

A specific example would be the child client who presents with obsessive-compulsive symptoms. The developmental level of clients will affect their presentation. Franklin, Riggs, and Pai (2005) note: ''Because children in general tend to be more magical in their thinking than are adults, our clinical experience has indicated that they are more likely to experience 'magical' or superstitious OCD, such as fears that failing to walk up the stairs repeatedly will result in harm befalling a parent'' (p. 131). The projective and expressive nature of the sandtray therapy experience provides a place where this ''magical'' thinking can be played out, and when appropriate eventually challenged.

In his discussion of CBT procedures with children, Kendall (2006) refers to the therapist's role as that of a coach:

> . . . I am referring to the therapist as person who does not have all the answers, but one who has some ideas worthy of trying out and some ways to examine whether the ideas have value for the individual. Telling a child and/or adolescent exactly what to do is *not* the idea; giving the client an opportunity to try something and helping him or her to make sense of the experience is the idea. The therapist as consultant collaborates with the client. (p. 9)

Sandtray therapy creates an ideal place for this experience. For many clients, especially children, *experience* carries more value than an *explanation.*

Children may be able to practice social skills, cognitive restructuring, exposure to anxiety-provoking material, problem solving, and so on. A simple comment from the therapist about a sandtray miniature that has experienced pain (perhaps directly representative of the client's experience or more general) can positively impact a client. Statements such as ''people (or animals) shouldn't be hurt like that'' or ''it must be lonely (or scary) for that animal, who just can't protect him/herself'' can touch a client's intrapsychic pain and open the door for deeper or more direct processes.

One therapeutic context where directive work in sandtray therapy may be incorporated is through family therapy. Using the sandtray with families is an excellent way to involve all family members, thus making it a truly systemic (inclusive) intervention. After family members have had the opportunity to express themselves through the medium of sandtray, directive exercises may be utilized, perhaps focused on problem-solving.

One example of this is an adaptation of the Kinetic Family Drawing, which has often been used as an assessment and intervention tool (Cook, 1991). The clinician asks the client(s) to individually or corporately make a drawing of the family (including self) and then verbally describe the drawing if necessary. The family doing something together is therapeutic in and of itself. Instead of drawing, however, the family members use a sandtray (or perhaps several small trays), using miniatures and creating action in the world of the tray(s). This directive technique can be used for assessment purposes, as an adaptation of family sculpting, and for psychoeducational work.

Solution-focused techniques can also be adapted well for use in the sandtray therapy process (Nims, 2007). In her text on solution-focused interventions, Webb (1999) addresses the issues of play therapy and sandtray therapy: ''Approaching children on their level fits with solutioning's emphasis on a shared world view, being with clients where they are, and working together or, with children, playing together'' (p. 251). Webb (citing Mostert, Johnson, & Mostert, 1997) asserts that ''children can first 'release their deepest wounds through the sandplay process' and then create new, different, more normal, solution-focused pictures'' (p. 252).

A specific directive technique that can be used in the sandtray is similar to the solution-focused ''miracle question'' (de Shazer, 1988), which serves to facilitate clients conceptualizing options, as well as a world beyond their current pain. Mills (1986) proposed a three-part art intervention, called the ''pain getting better'' technique. She has her child clients draw three pictures: (a) a picture of the pain; (b) a picture of the pain ''all better'';

and (c) a picture of what will help picture number one change to picture number two. Besides the benefit of using the projective nature of the art intervention (which serves to create a level of therapeutic distance), this helps the child begin to consider that life can indeed get better. This can easily be used as a sandtray intervention using three small trays. The previously noted sandtray benefit that no artistic talent is needed makes this a less threatening intervention.

The appropriate timing of solution-focused interventions in the sandtray is a crucial component. If clients have not experienced adequate safety and processing of intrapsychic issues, becoming too directive can be intrusive and discounting. Gil (2006) cautions the therapist to avoid the temptation to quickly make observations or ask questions, particularly in case of post-traumatic sandtray work. On the other hand, an opportunity for problem solving may be lost if the sandtray therapist does not take advantage of an established therapeutic rapport and the ability to adapt the sandtray process in a more direct manner.

REVIEW OF SANDTRAY LITERATURE AND RESEARCH

Although it is not possible to give a comprehensive review of the sandtray literature, it is important to note that sandtray is an intervention backed by history and research. There are compelling case studies and research on the application of various sandtray interventions with different populations.

Mayes and Mayes (2006) discuss the use of sandtray therapy with a schizophrenic woman. Multiple studies have explored the use of sandtray with survivors of trauma and abuse (Berman, 1993; Shaia, 1991; Toscani, 1998). Several authors discuss cases of using sandtray with children experiencing abuse and psychic trauma (Grubbs, 1994; Miller and Boe, 1990; Zinni, 1997). Lee (1998) studied the qualitative response of menopausal women to sandplay therapy. Wood (2004) studied the ego maturity of a prelingually deaf boy using sandtray. Sandtray has also been used in the context of group therapy (Draper, Ritter, & Willingham, 2003; Hughes, 2004; James & Martin, 2002). Borkan (1991) and Keating (1995) did their dissertation research on using sandtray therapy with mentally retarded clients. Sparling (2002) explored the use of sandplay as a complementary intervention for breast or ovarian cancer treatment.

Different applications of sandtray therapy have also been discussed in the literature. Spooner and Lyddon (2006) describe a constructivist application of sandtray for inpatient sexual addiction treatment. Adlerian approaches to sandtray therapy have been reported (Bainum, Schneider, & Stone, 2006; Sweeney, Minnix, & Homeyer, 2003). Several dissertation studies have explored researched Jungian applications to sandplay and the use of self in the sandtray process (Cameron, 2002; Lewis, 1991; Scott, 2003). Wasserman (2002) explored the use of sandplay therapy combined with cognitive restructuring in the treatment of an 11-year-old female.

Sandtray therapy has also been studied with diverse populations. Bonds (1995) explored the use of sandtray with inner-city Latino and African American adolescents. Artico (2000) also used sandtray with Latino adolescents, and Mejia (2004) studied the use of sandtray with Mexican farm worker women. Hunter (1995) studied the use of sandtray with inner-city African American and Hispanic boys. Fernando (2006) explored the use of sandtray with children of war in Sri Lanka. Sandtray has been explored with Chinese clients (Shih, Kao, & Wang, 2006; Zhang & Kou, 2005) and Japanese clients (Enns & Kasai, 2003). Cohn (2000) and Burke (1996) studied gender differences among children in the sandtray process. Lenhart (1988) examined the use of sandtray with gay men, and Baker (2004) discussed sandtray with older adult clients.

Using a pretest-posttest control group design, Wang Flahive and Ray (2007) demonstrated the effectiveness of group sandtray therapy with adolescents, showing statistically significant results measuring externalizing behaviors. Comparing sandtray therapy with behavior management as an intervention with kindergarten through fourth-grade students, Zarzaur (2005) demonstrated that both interventions showed similar behavioral improvements. Mason (1986) assessed marital satisfaction and couple integration using sandplay therapy.

Simourd (1999) did a qualitative study using sandtray therapy with siblings of children with cystic fibrosis, reporting that the intervention assisted in rapport building and facilitating expression. Freedle (2006) examined sandtray with adults having moderate to severe brain injury. Shen (2006) studied the impact of school-based group sandtray counseling on the self-esteem of young adolescent girls, demonstrating through split-plot analysis of variance that the intervention was effective.

Miller (1979) did a qualitative study on using sandtray, concluding that sandtray therapy is a nonverbal, projective, therapeutic tool that can be effective with adults. Cunningham (2003) researched the issue of countertransference in sandplay. Beggs (2004) studied the use of sandtray with families, with the result of families in the sample finding the therapy helpful and children feeling included in the therapy process.

Sandtray therapy has also been used in the context of couples therapy (Carmichael, Echols, & Warren, 1997; Sweeney, 2002).

The therapeutic and spiritual elements of sandtray therapy have also been examined. Mandelbaum (2006) did a qualitative study of the central concept of the therapeutic container in sandplay therapy. Graham (2006) and Fitzpatrick (2001) studied sandtray as a spiritual practice. Erdem (2000) explored the use of sandtray as an agent of hope for children who had been sexually abused.

SUMMARY

There are multiple applications for sandtray therapy, both as a primary and secondary mental health intervention. It can be a wholly expressive and projective intervention, with talk therapy taking a back seat to the nonverbal process. The safety created by the therapeutic distance of projection is invaluable when working with traumatized clients. Sandtray can also be part of an eclectic therapeutic milieu. Treatment techniques can be adapted for use in the sandtray, and the sandtray therapist can be as directive or nondirective as the treatment context calls for.

Arguably, however, hurting people are not healed through techniques. The underlying intrapsychic and interpersonal turmoil that generates symptoms needs to remain the focus of therapeutic intervention. Sandtray therapy lends itself to being an internal and relational process. The sandtray therapist needs to recognize the value of cognitive processes, but not force techniques that are developmentally inappropriate, either in terms of client chronological age or stage of therapy. Spare (1981) wrote of sandplay, though it can be applied to all sandtray interventions: ''As with every aspect of clinical practice, meaningful use of sandplay is a function of our own human hearts, and of the ever ongoing interplay between our own centers and the centers, hearts, and needs of those we are privileged to see in psychotherapy'' (p. 208).

Sandtray therapy continues to enjoy increasing popularity among psychotherapists seeking to employ expressive interventions with their clients. Before closing, however, it should be noted that its increased usage has not always been accompanied with adequate training and experience. The interested reader is encouraged to seek adequate training, supervised experience, and personal sandtray therapy. With an acknowledgement of the authors' bias, sandtray therapy is much more than a mere treatment modality. It is a journey for the hurting to heal and the healthy to grow. The therapeutic road should see more footprints in this sandy path.

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SECTION V

INTEGRATION AND APPLICATION OF PLAY-BASED TECHNIQUES WITH CBT

THE PURPOSE OF this section is to help readers become aware of the many practical play-based techniques and resources available for working with children and adolescents across a variety of treatment approaches. Many verbal CBT treatments help children and adolescents deal with affect regulation, create narratives of their trauma and experiences, improve self-esteem and coping skills, and address cognitive distortions and low frustration tolerance. Chapters in this section offer play-based techniques and strategies that address these same areas, while engaging children and adolescents, and simultaneously sustain their interest and motivation in a playful manner. This section is rounded out with a chapter on how together cognitive behavioral approaches along with expressive activities can be utilized in family therapy.

Susan Knell and Meena Dasari in the first chapter give an overview of Cognitive Behavioral Play Therapy and its phases. The authors include a list of the various play materials to include in the therapy space, along with how to use puppets and other play materials effectively with CBT and children. The chapter is peppered with practical approaches and ways to implement and respond verbally in the session with cognitive and behavioral interventions. A section is devoted to troubleshooting and how to handle common problems. A case study rounds out the chapter and brings to life the various materials that were previously discussed.

The second chapter by Susan Trachtenberg Paula narrows the focus to play therapy techniques that can be utilized for affect regulation. The author deftly weaves in the various play therapy and play-based activities, while breaking down the treatment components through the use of a case study that is presented so the reader can see the practical application of the various techniques and rationale. This chapter becomes a how-to for even the seasoned clinician in the best way to utilize play therapy within CBT.

Diane Frey in Chapter 18 offers a plethora of creative techniques with which to help address self-esteem, coping skills, and cognitive distortions. She helps the reader understand the benefits of play therapy and CBPT for any age client, even adults, especially when the client is resistant to the treatment process. Many of the techniques were created by the chapter author and are fun-filled and easy to use. A case study helps bring alive the application of the previously read techniques that are spelled out as she goes through the sequential phases of treatment.

Chapter 19 by Eva Feindler offers a practical, hands-on focus of playful strategies and techniques to help children manage their anger and aggression as a result of frustration. The author describes several CBT programs that help to strengthen the emotional and social competence of young children. In particular she focuses on bibliotherapy and an array of play-based programs designed to help young children identify, understand, and manage their emotions in fun-filled ways. This chapter is a practical tool for working with any type of population.

In Chapter 20 Ann Cattanach offers the reader a rich narrative experience both in reading the case studies and stories of the children being helped to create their own personal narrative and in her flowing prose about the process. The author offers a historical perspective on the use of narrative therapy in play therapy, as well as insight into the creative narrative process and how best to structure the activity for participation by children and adolescents. Detailed descriptions of materials needed, use of toys for pretend play, and rules when playing together are useful for the beginner in entering the child's narrative world. Child clinicians and play therapists working with sexually abused and traumatized children have found that the telling of a personal narrative of the abuse is helpful and therapeutic in the healing process. This chapter offers a clear guideline in how best to set up that process.

This section ends with Chapter 21 by Steve Harvey on how to use expressive activities for family problem solving in therapy. A family case study follows with the author sharing his rationale for using various play-based activities and making clear their implementation. It is a practical guide for creating a safe and playful environment where the full family can enjoy participating.

CHAPTER 16

CBPT: Implementing and Integrating CBPT into Clinical Practice

SUSAN M. KNELL
MEENA DASARI

Cognitive behavioral play therapy (CBPT), which was developed by incorporating cognitive and behavioral interventions within a play therapy paradigm, was introduced into the psychotherapy literature in the 1990s. Prior to its inception, most play therapy techniques were based on either psychodynamic or client-centered theories. With both of these earlier theoretical approaches, play therapy was unstructured and guided by the child. CBPT provided a novel theoretical approach to child psychotherapy, in that the most significant differences between CBPT and other play therapies are its structure, psycho-educational components, and goal-directed and collaborative approaches (i.e., guided by both child and therapist). A more comprehensive description of the theory and applications of CBPT can be found in Chapter 4.

Descriptions of the theory and applications of CBPT have been published in the literature (Knell, 1993a, 1993b, 1994, 1997, 1999, 2000, 2003; Knell & Beck, 2000; Knell & Dasari, 2006; Knell & Moore, 1990; Knell & Ruma, 1996, 2003). Several of these writings include case examples describing the successful use of CBPT with children with selective mutism (Knell, 1993b); separation anxiety (Knell, 1999); anxiety disorders (Knell, 2000; Knell & Dasari, 2006); and histories of sexual abuse (Knell & Ruma, 1996, 2003). CBPT has also been used with children who have sleep problems (Knell, 2000a), who are acting out (Knell, 2000), and who are experiencing parental divorce (Knell, 1993a). A number of writings include more specific and detailed descriptions of the application of CBPT, including transcribed therapy sessions (Knell, 1993b) and commentary about specific clinical decision making (Knell, 1993b, 1997).

CBT with children has been shown to be effective in treating several emotional and psychosocial problems, such as depressive disorders, anxiety disorders including obsessive compulsive disorder and posttraumatic stress disorder, attention deficit hyperactivity disorder, anger, sleep problems, and grief (Kendall, 2006). Although such empirical support is not specific to the implementation of CBT in play, CBPT may be effectively adapted for the treatment of these disorders as well, given that similar cognitive and behavioral techniques are used. The major difference is that CBPT is implemented within a play therapy modality.

The present chapter will extrapolate from this literature by discussing the implementation of CBPT and the methods for integrating into clinical practice. A discussion of the use of play materials, such as puppets and other toys, will be included. The importance of play assessment, as part of the CBPT process will be considered. The integration of empirically supported cognitive and behavioral techniques within a play therapy paradigm will be discussed. Unique to this chapter will be very real-life oriented, ''how to'' descriptions highlighted with actual case examples. Finally, implications for clinical practice are reviewed.

HISTORICAL USE OF PUPPETS AND OTHER PLAY MATERIALS IN PLAY THERAPY

PUPPETS

Puppets have long been used as a medium to reach children and to provide a means for communication within the therapy context. Seminal work by Bender (1952) encouraged the use of puppets. Puppet play may be active (e.g., having children create their own stories) or vicarious (e.g., producing a puppet show) (Bender & Woltmann, 1936). In Bender and Woltmann's work, which is now more than 70 years old, the authors discussed the need to ''reach'' children who were being treated for severe behavioral problems. They found that puppet play allowed children to project their own problems onto the puppet characters. Therefore, the puppet shows were thought to serve as a vicarious means of expression for the children to explore conflicts without producing significant anxiety.

Irwin (1985) suggested the use of puppets for individual assessment of children's current functioning. Puppets were chosen due to the richness of expressive material produced through the child's spontaneous play. The child was asked to select various hand puppets and to create a pretend television story. At the end, the clinician interviewed the characters and the puppeteer in order to follow up on clinical hypotheses and to seek clarity from the child and the ''characters'' in the story. This method was also developed for use with families (Irwin & Malloy, 1975).

In 1991, Irwin presented an extensive review of the use of puppets to aid in diagnosis and treatment of children and families. For younger children, she reported that puppet play was less censored and more openly full of conflict. In addressing developmental considerations in using puppets, Irwin noted, ''Young children often present their conflicts with startling clarity and lack of disguise, thus helping illuminate the diagnostic picture (Irwin, 1991, p. 620). In a review of clinical and research literature using puppets, Irwin (2000) hypothesized that puppets offer universality and ambiguity in terms of identification, and an avenue through which the child's fantasy can appear.

Although various toys may be used in play therapy, puppets are the most commonly used play materials. They provide a nonthreatening means of expressing conflicts and feelings *for* the child and not *by* the child. From the child's perspective, it may feel like the puppet is expressing the conflict or feeling and not the child, per se. There has been some thought that the hand manipulations required to guide the puppet may help the child enter the play (Woltmann, 1960). The child's hand movements and voice are the carrier of the ideas, which, for the child, are expressed by the puppet.

In more recent literature, puppets have been used in the delivery of a wide variety of play therapies, including assessment and interventions for CBPT (Knell, 1993a, 1993b, 1999; Knell & Beck, 2000) In most cases of CBPT, the puppets are used as a means of delivering specific cognitive and behavioral interventions, through modeling and/or role-playing.

OTHER PLAY MATERIALS

Other play materials can be used to effectively implement CBPT. Numerous authors have written extensively about the use of other play materials in play therapy. In her book *Play Therapy*, Axline (1947) listed guidelines for play materials, a list that is still commonly quoted and used. However, an enormous number of toys have been developed in the 60 years since her book was written. Landreth and his colleagues (Landreth, 2002; Giorano, Landreth, & Jones, 2005), writing from a client-centered perspective, described the toys used to communicate experiences, feelings, and needs. He categorizes toys, acknowledging that they may be used in multiple categories, to areas of nurturance (dolls, bottle, medical kits), competence (blocks), aggression release (animals such as tiger, lion, alligator; soldier figures), real life (dollhouse and figures, play money), fantasy/dress up (hats, clothes, masks), and creative expression and emotional release (water, sand, art materials). Toys are organized, easily accessible to the child, and chosen by the child, rather than by the therapist.

At the other end of the continuum are play therapies that do not rely heavily on play materials. In a unique approach known as Ecosystemic play therapy, play materials are thought to be secondary to the therapist (O'Connor, 1997; O'Connor & New, 2003). In Ecosystemic play therapy, the focus is on the interaction between child and therapist, not the child and play materials. Children in Ecosystemic play therapy are not allowed free access to play materials, but rather the therapist chooses specific play materials, suited to the individual child, prior to each session.

In the CBPT literature, play materials are a critical component of therapy, with both child and therapist choosing appropriate materials either collaboratively or independently. As discussed in a subsequent section, the playroom is well stocked with a wide array of toys/play materials and, at times, an individual child's presenting problems may require an object not typically found in the play room.

PHASES OF CBPT

INTRODUCTION AND ORIENTATION

It is important to orient and to prepare both the child and the parents for CBPT. Typically, the parents and therapist will meet together, without the child present, so that the therapist can complete a clinical interview to gather history and background information as well as obtain any rating scales from the parents. Also, if necessary, psycho-education on therapy structure and parental involvement should be provided. In addition to assessment, the CBP therapist can talk with the parents about preparing the child for therapy. The therapist can guide the parents in what to say to the child before he/she comes to the first session. Honesty is important, though the discussion should be developmentally appropriate. In a simple, noncritical way, the parents can describe their concerns and what they have done (e.g., talk to a therapist) to seek help.

Parents should avoid language or explanations that sound threatening (e.g., "You will need to behave or I'm going to tell the doctor what you are doing''), involve a lie (e.g., ''We are going to play with friends''), or are bribes (e.g., ''If you talk to the doctor, I'll buy you a treat'') (Dodds, 1985). The parents can be coached to make a statement, such as,

> We are concerned about how you are feeling. We know that you get nervous and worry about a lot of things. We went to talk to someone about it. She is a ''feelings'' doctor. She talks and plays with kids who are worried about things. Next time we go, you will go with us, and have a turn talking and playing with her.

It is recommended that parents also normalize the symptoms and experience (e.g., ''she sees a lot of kids who worry and helps them'') as well as highlight the child's strengths that will help in therapy (e.g., ''getting along well with adults,'' ''smart''). It can also be helpful for the parents to describe the therapist (e.g., ''she is nice'') or the office (e.g., ''she has lots of fun toys'').

Bibliotherapy can also be used as a resource for preparing the child for therapy. The book, *A Child's First Book About Play Therapy* (Nemiroff & Annuziata, 1990) provides an introduction to play therapy for 4–7-year-olds. Books such as this one can help prepare the child, as well as the parents, in understanding what to expect. Therapists can also use the book in the early stages of therapy, if it is felt to be helpful to the child.

ASSESSMENT

Assessment of Play Skills

In addition to formalized assessments (i.e., clinical interview, rating scales) of children's symptoms, understanding children's pretend play ability is important in determining whether CPBT is an appropriate intervention for a child. Research has shown that play therapy is more effective for children who already have good pretend play skills (Russ, 2004). Four skills are thought to determine the quality of a child's pretend play. These include (a) cognitive skills such as organization, divergent thinking, and symbolism; (b) emotional skills such as emotional expression, comfort/enjoyment of play, and emotional regulation; (c) interpersonal/social skills such as empathy and communication; and (d) problem-solving skills such as approach to problems and conflict resolution ability.

We recommend using a combination of assessment methods to estimate the child's developmental level of cognitive, emotional, social, and problem-solving skills. These include any combination of the following:

clinical interview or parent report, child self-report, therapist behavioral observations, and/or school evaluations. In general, the purpose of the assessment is to determine whether the child's skills are similar to same-age peers. First, parents should be asked about the quality of pretend play (e.g., what are some different games that the child plays?). Both the parents and the child should be asked about favorite play materials.

Cognitive skills and problem-solving skills can be assessed using school report cards (e.g., qualitative descriptions, grades) or psychoeducational evaluations (e.g., IQ scores). Emotional skills can be determined during the clinical interview. Parents are asked to describe the frequency and intensity of the child's emotional experiences such as anger, sadness, anxiety, frustration, and so on. The child's ability to cope with these emotions should also be determined. The therapist can supplement this information with behavioral observations of the child's ability to express and regulate emotions in a therapeutic setting. Interpersonal/Social information may be better understood through the behavioral observations. The therapist can use free play to see how the child communicates with the therapist within play as well as if/how empathy is expressed.

It should be noted that, if a child's skills in one or two areas are below his/her developmental level, CBPT may still be a useful intervention. CBPT can be adapted based on an individual child's needs. For example, a child with low ability for verbal expression can be asked to use more gestures and drawing to supplement verbalizations. At first glance, one might think that CBPT is not indicated for children with serious deficits in cognitive, emotional, or social functioning. However, appropriateness for CBPT should be determined on an individual basis, particularly since one of the hallmarks of CBPT is its flexibility and reliance on individualization of treatment.

ASSESSMENT OF EMOTIONAL/BEHAVIORAL FUNCTIONING

More structured play assessments may be used in addition to other assessment methods. A number of such assessment measures, described in Gitlin-Weiner, Sandgrund, and Schaefer (2000), include scales for assessing therapeutic play, tapping both affective and thematic characteristics of play. Projective techniques, with their long history in the assessment literature, might not seem compatible with more cognitive behavioral approaches. However, a less structured, more projective task, such as a sentence completion, does lend itself to providing clinical information about a child's emotional and behavioral functioning prior to CBPT. Knell (1992, 1993a, Knell & Beck, 2000) proposed the use of a puppet sentence completion task (PSCT) as a developmentally sensitive assessment measure of young children. The PSCT is a structured, projective measure designed to facilitate a young child's participation in the sentence completion process. It is more developmentally suited to the young preschool and school-age child.

Another relevant assessment measure is the Affect in Play Scale (APS) for school-age children (Russ, 1987, 1993) and (APS-P) for preschool-age youth (Kaugars & Russ, 2000). The APS, a rating scale based on behavioral observations of a child's play developed as a standardized measure of affective expression in pretend play, has also been used to assess cognitive, emotional, and social skills in children's play. The APS requires videotaping of sessions, as well as therapist training that includes coding of tapes, inter-rater reliability, and other qualitative research methodologies. Though more widely used in research, the APS is rarely used in clinical practice, in part because of the complexities of administration and scoring. Recent developments include a brief rating version of the APS that does not require videotaping, which may be more appropriate for the clinical setting (Sacha, Russ, & Short, in press).

Play Materials. CBPT is usually conducted in a playroom or office equipped with appropriate play materials. To some extent such materials can be chosen by the individual CBP therapist. Ideally the room has a variety of toys, art supplies, puppets, dolls, and other materials, such as the following suggested items:

- Puppets: dog (for children with dog phobias), alligator or shark (for use with children who bite, or have issues with the expression of aggression), turtle (for children who are shy or have social anxieties)
- Construction paper of different colors
- Markers/crayons
- Dollhouse: include toilet (for children with toilet issues) and bed (for those with sleep problems)
- Family set of figures, includes mother, father, sibling-male, sibling-female, baby. Ideally there should be families representing different ethnic/racial groups.
- Books on many different topics, including those related to moods/feelings, anxiety/fear, divorce, going to a new school, and so on. (See Appendix A for recommendations.)
- Toy cars
- Games to build therapeutic alliance: *Checkers*, *CandyLand*, *Connect Four*

- Therapeutic games: *Talking, Feeling, Doing Game; Ungame*
- Clay or Play Doh
- Legos or other building supplies
- Feeling faces, posters, and feeling blocks
- Stickers: particular ones that tie in with therapy themes (e.g., sign language ''I love you stickers'' from *The Kissing Hand*, trains from the *Little Engine That Could*, positive reinforcement themes)
- Dry erase board
- Worksheets with pictures of people or animals with thought bubbles above their heads

Although an array of toys is usually sufficient, there are times when a specific toy may be needed to treat a particular child. At times, play materials that are available can be adapted to meet these specific needs. At other times, a specific toy may need to be brought into the playroom, because the child cannot pretend or be flexible in the use of already existing toys. An example of this would be a child who was having a difficult time wearing prescription glasses. She might be able to cut out glasses on paper and use these with a doll. Or, the child might have difficulty with this flexible use of the paper-cut glasses, and might respond better to actual plastic glasses that fit the doll.

Sometimes play therapy is conducted outside the playroom/office in environments that more closely resemble specific real-life situations. This is particularly true for children with specific anxieties, particularly phobias that are best treated in vivo. For these children, treatment may take place in a setting that more closely resembles the feared situation. Treating children via CBPT in vivo is most likely when a systematic desensitization paradigm is used. For example, systematic desensitization of elevator-phobic children can take place in and around an elevator (Knell, 1993a, 2000); a child with obsessive-compulsive disorder may be treated in a setting that elicits obsessions and compulsions (March & Mulle, 1998).

SETTING UP THE PLAY THERAPY ROOM

A number of authors have written extensively about setting up the play therapy room (Giorano, Landreth, & Jones, 2005; Landreth, 2002; O'Connor, 1991). Giorano, Landreth, and Jones (2005), from a client-centered perspective, describe specifics of the room, including size, characteristics (e.g., flooring, shelving), as well as the design and organization of toys in the room. For CBPT, two requirements should be met: Toys are (a) visible and (b) easily accessible to the child. Additionally, there should be some predictability, with toys kept in the same place so that the child knows where they are from one session to the next. If the child is working on a project or has papers (e.g., pictures, individual, self-created book), it is important that the therapist and the child have a safe, consistent place to keep these materials. They should not be out on display for other children, who might touch or destroy them. Rather, they should be in a locked drawer/place, so the child knows that his/her confidentiality is being respected.

METHODS OF DELIVERING CBPT

MODELING

Modeling is a very important part of play therapy with young children who may not understand more verbally oriented therapies. Extensive research shows that modeling is an effective way to acquire, strengthen, and weaken behaviors (Bandura, 1977; Ollendick & King, 1998). In CBPT, modeling exposes a child to someone or something (often a stuffed animal or toy) that demonstrates the behavior to be learned. It can be especially useful if the child can relate positively to the model. It can also be presented through books, films, and so on.

In CBPT, the therapist uses modeling to demonstrate adaptive coping methods. For instance, the model (e.g., puppet) may verbalize problem-solving skills, in that the therapist talks out loud at each step, which provides auditory cues as well as a concrete example. Thus, the model can use self-instruction, allowing him/her to stop and think before overtly responding (Meichenbaum & Goodman, 1971). In other words, the therapist is presenting the more verbal components of therapy, through modeling, in a more child-friendly way and in a coping model (Bandura, 1969; Meichenbaum, 1971). The therapist may comment out loud and deal with issues that are brought up by the puppet. The puppets are reinforced for efforts along the way (shaping). The puppet will struggle, falter, problem solve and eventually learn better coping skills. In this way, the model does not provide a flawless performance (as would be the case with a mastery model). Thus, the model demonstrates how the problem can be solved and supports the idea that no one is perfect.

In creating possible puppet scenarios, it is important to be flexible and create dialogues that are focused on treatment goals. It is equally important to take into account the child's spontaneous verbalizations and behaviors and incorporate this information into the puppet scenes. These scenarios should evolve over time and be based in part on the child's responses and interactions with the puppets.

ROLE-PLAYING

Although often done through modeling, role-playing is another way to deliver CBPT, especially with younger children. In role-playing, the child practices the skills with the therapist and receives ongoing feedback. When delivered through modeling, the model role-plays situations, and the child observes and learns from watching. For example, a child with separation anxiety may observe as a puppet, reluctant to separate from her mother, practices leaving mom, saying goodbye, and going to school. The child listens and watches the puppet and observes the feedback the puppet receives from the therapist.

STRUCTURED VS. UNSTRUCTURED PLAY

In CBPT, the process of change is considered to take place in both the structured and unstructured components of the sessions (Knell, 1993a; 1999). In the unstructured components, the therapist can gain a sense of the child's own thoughts and perceptions by observing the spontaneously generated material brought to the session by the child. Alternatively, the structured, goal-directed activities provide the therapist the opportunity to work with the child on problem solving and teaching more adaptive behaviors. The balance between the structured and unstructured components of the sessions is critical. There are a number of ways that CBPT sessions can be structured. The process of CBPT will be described with puppets. This is because CBPT with puppets is the most widely used and written about, and because it is a modality enjoyed by most children. In a later section, structuring of CBPT sessions with play modalities other than puppets will be considered.

It is usually helpful to structure the therapy sessions by using several puppets with a variety of problems. Two or three puppets are chosen. The therapist names them (or if the child is willing, the child helps the therapist give them names). Finally, the therapist identifies the puppets' problems. At least one of the puppets should have a problem that closely matches the child's problem (e.g., "This puppet gets sad when her mom leaves her at school. Sometimes, she starts to cry and doesn't want her mother to leave.").

INTERVENTIONS: INTEGRATING EMPIRICALLY SUPPORTED TECHNIQUES INTO CBPT

CBPT is developed using a cognitive behavioral theoretical model and by integrating empirically supported techniques into play therapy that are adapted to the developmental level of the child. The CBT model proposes that a relationship exists between thoughts, emotions, and behaviors. Specifically, environmental events trigger a set of thoughts that lead to certain emotions, which then lead to certain behaviors. The approach is structured, goal-oriented, therapist and child directed, and emphasizes skill building. Several empirically supported techniques from the CBT literature are incorporated into the play as used to help children to build skills. All techniques are adapted to the developmental level of the child's cognitive, emotional, and social skills.

In general, research suggests the combination of cognitive and behavioral interventions are effective in helping children cope with difficult events and emotions (for reviews, see Compton et al., 2004; and Velting, Setzer, & Albano, 2004). Cognitive techniques include psycho-education, cognitive restructuring, positive self-statements, and problem solving. Behavioral techniques include relaxation, exposure, systemic desensitization, and contingency management. In the next section, cognitive and behavioral techniques are described and examples of how the technique is integrated into play are listed in Table 16.1 and Table 16.2.

Table 16.1
Examples of Cognitive Interventions

Technique	Example	Recommended Play Materials
Psycho-education on Emotions	A child marks feelings on a scale with faces representing emotions.	Scale with emotional faces corresponding to ratings; pictures of the child making various "feeling faces"
Cognitive restructuring - Identifying cognitive distortions	A child who is defiant with parents is given pictures of parent-child interactions and asked to capture thoughts and feelings about situations.	Crayons/markers Construction paper Worksheets with thought bubbles Puppet who fights with parents

(*Continued*)

Table 16.1
(Continued)

Technique	Example	Recommended Play Materials
Cognitive restructuring - Challenging cognitive distortions (maladaptive thoughts)	A puppet notes that no one likes him because another puppet is teasing him. The therapist walks the puppet through the process of examining this, by talking about his friends, exploring other reasons why he was teased, and trying out his friendships with other puppets.	Puppets/toys that the child identifies with Dry erase board to write out thoughts Note cards with thought challenging questions
Positive Self Statements	A doll that is afraid to go swimming says, "I can get in the water. I will be ok when I get myself wet."	Doll that child can identify with Construction paper to write down thoughts
Bibliotherapy	A child whose parents are divorcing reads a book about another child or character whose parents are also divorcing. During the reading, or afterward, the therapist normalizes different emotional experiences and highlights adaptive thoughts.	Developmentally appropriate book on divorce, particularly a book that challenges common cognitive distortions (e.g., "It is my fault that my parents are getting divorced")
Problem Solving	A child who is getting bad grades in math is introduced to a puppet that doesn't understand his math homework. The puppet talks aloud stating the problem and the desired goal (understanding my homework). Then, the puppet and therapist list a variety of strategies (e.g., "ask my parents for help" or "talk to my teacher") and selects the preferred one. Puppets role play the strategy and discuss the outcome.	Puppets Dry erase board to write out strategies Child's homework worksheet

Table 16.2
Examples of Behavioral Interventions

Technique	Example	Recommended Play Materials
Relaxation training	Therapist introduces deep breathing by having a puppet do it first. Child and therapist practice it together by placing a stuffed animal on their stomachs and watch as the stuffed animal rises and falls with the deep breaths.	Puppet that child identifies with Stuffed animals Fun counting strategy for number of breaths
Systematic Desensitization	A doll who is clingy with mom and unable to remain in school sits in the school setting without mom present, while simultaneously engaging in relaxing activity (mutually exclusive with anxiety) such as playing with her favorite toy.	Doll that child can identify with Mother figure doll Child's favorite toy
Exposure	A puppet who fears dogs goes through a "fear ladder" consisting of situations least to most feared (e.g., looking at pictures of dogs to petting dog in the therapy room). Therapist helps puppet remain until the fear decreases.	Visual drawing of a fear hierarchy Puppet that child identifies with Pictures of dogs (real and/or cartoon) Dog Stickers/Sticker chart
Contingency management – Positive Reinforcement	A puppet who is fearful of reading out loud receives stickers for each attempt to read to another puppet.	Stickers/Sticker chart Note cards with praising statements Food reinforcer
Contingency Management – Shaping	A puppet who is fearful of talking to new people is asked to begin with one word greeting and proceeds to short sentence, and then to 1 minute conversation.	Sticker chart Toy that child can identify with

(*Continued*)

Table 16.2
(Continued)

Technique	Example	Recommended Play Materials
Stimulus Fading	A doll who is clingy and unable to sleep in its own bed at night when mom tucks him in, but ok when dad tucks him in, is initially tucked in by dad. Gradually mom is faded back into the nighttime routine.	Dollhouse with bed Mom, dad, and child figure
Extinction/DRO	A puppet is acting aggressively to other puppets and doesn't receive any positive attention for her behavior (Extinction), while more adaptive behaviors (playing nicely, keeping hands to herself), and using appropriate words, rather than action (DRO) are rewarded.	Poster with "rules for playing nicely" Puppet or toy that child can identify with

COGNITIVE TECHNIQUES AND CBPT

Psycho-Education. From a CBT perspective, psycho-education refers to teaching a child about his/her disorder, normalizing symptoms, and explaining the CBT model (Compton et al., 2004). With a CBPT approach, psycho-education is adapted for children's developmental level through the use of either modeling or bibliotherapy. Modeling is incorporated by the child observing the therapist teaching a puppet (a) about his difficulties and (b) about his thinking affecting his feelings and behavior. Bibliotherapy refers to the use of therapeutic books or popular children's literature to educate the child on typical development.

Cognitive Restructuring. Cognitive restructuring refers to techniques that train children to change their negative thinking to more positive, realistic thinking (Compton et al., 2004; Velting, Setzer, & Albano, 2004). The underlying theory for cognitive techniques is that negative emotions are a result of maladaptive cognitions, or negative thinking, about events in the environment. Thus, it is hypothesized that changes in thinking will produce changes in behavior. The cognitive change strategies used with children involve (a) identifying negative thoughts, (b) asking questions about alternatives and evidence to contradict, and (c) generating a new positive or neutral thought. Knell (1993a, 1993b, 1994, 1997, 1998, 1999) contends that cognitive change strategies can be adapted to the developmental levels of even young children. With children in CBPT, the therapist helps the child identify, modify, and/or build cognitions by presenting these concepts in an age-appropriate way. Often, children present with more neutral thoughts, representing a lack of positive self-statements rather than the existence of negative self-statements. In these cases, the child can be helped to add positive statements. Further, for children with negative self-statements, the replacement of neutral statements for negative ones can be an intermediate step (Kendall & Treadwell, 2007).

Changing a child's negative thoughts is illustrated by work with a child with concerns about going to a birthday party. The child could be taught to identify negative thinking like ''the kids won't like me'' or ''I'll be really bad at the party games.'' Such thoughts may lead to anxious feelings and behaviors (e.g., wanting to stay home, stomachaches, avoiding the party by hiding in the bathroom). The child can learn more neutral and positive thoughts: ''Birthday parties are okay,'' ''Birthday parties can be fun,'' ''I am good at party games.'' The therapist would model the use of questions such as ''What has it been like before?'' and ''What are some other things that could happen?'' Such modeling can take place with and without play materials, but it happens in a developmentally appropriate way.

Positive Self-Statements. The development of positive self-statements, or adaptive coping self-statements, is a technique that teaches children to say clear, self-affirming statements to themselves (Velting et al., 2004). Turning external praise from parents and adults into self-statements is not automatic, and children must be helped to develop positive self-affirming comments. However, for CBPT, positive self-statements must be adapted to the child's age and developmental level and can be used in the absence of negative thoughts. Children should be taught statements that are linguistically and conceptually simple (e.g., ''I am brave,'' ''I can do this''), which can contain an element of self-reward (e.g., ''I am doing a good job''). Also, children may not be able to identify any thoughts and, in these cases, they can be coached to use positive self-statements as a way of cheerleading themselves in the situation. Thus, these positive statements are built on either neutral or even nonexistent statements, rather than replacing negative self-statements.

In CBPT, positive self-statements should be modeled by the therapist. Children learn the positive value of their actions through specific labeling by significant adults, with positive feedback from those adults. Positive self-statements can also prompt children to implement coping strategies through active control (''I can walk past the dog whenever I feel like it''); reducing aversive feelings (''I will be able to go to school whenever I am ready''); reinforcing statements (''I am brave''); and reality testing (''There really are no monsters in our house'') (Schroeder & Gordon, 1991).

Problem Solving. Problem solving refers to teaching children a systematic technique for identifying active ways of coping and testing possible outcomes (Velting et al., 2004). Five steps are involved and include (a) identifying the specific problem and the desired goal; (b) brainstorming possible strategies to achieve the goal; (c) exploring the pros and cons of each strategy; (d) implementing the preferred strategy; and (e) evaluating the outcomes. The therapist can implement this technique into CBPT through the use of modeling and role-playing. For example, for a child who is getting teased at school, a puppet that also gets teased in school is introduced into play. The puppet talks aloud stating the problem and the desired goal (i.e., ''making the teasing less''). Then, the puppet and therapist list a variety of strategies, such as ''walk away,'' ''ignore them,'' ''tell my teacher,'' ''tell my parents,'' ''tease them back,'' ''avoid recess,'' and ''stay home from school.'' The puppet evaluates all the strategies and selects one or two with more possible pros than cons (e.g., ''walk away'' and ''tell my parents''). Then, the puppet role-plays the strategies with other puppets and talks through the outcome (e.g., ''that helped me to feel more in control'').

BEHAVIORAL INTERVENTIONS AND CBPT

Relaxation. Relaxation training is a behavioral technique that teaches children to calm their body. Three different relaxation methods may be used: (a) deep breathing, (b) imagery, and (c) progressive muscle relaxation. All methods can be taught, and then the child, in collaboration with the therapist, selects which works best. Relaxation training can be integrated into CBPT by modeling a state of calm for the child. There are various ways that this might occur, such as by teaching a puppet muscle relaxation or deep breathing and having the child observe. Books and tapes are often used with young children. One example is the book *Cool Cats, Calm Kids* (Williams, 1996), which models relaxation skills through the body posture and self-statements of cats.

Exposure. Exposure is a critical behavioral technique and refers to the gradual and systematic confrontation of anxiety-provoking stimuli resulting in habituation (i.e, anxiety subsides or decreases due to repeated exposure). This can be done either in vivo or using imagination. When setting up in vivo exposure paradigms with children, it is important that the therapist adapt the task to the child's developmental level and readiness to confront difficult tasks. This is done using a fear hierarchy, which asks the child to organize tasks from least difficult to most difficult. For example, with a child who is clingy and unable to sleep in his/her own bed, a fear hierarchy would organize tasks from ''sleeping on parents' floor for one night'' to ''sleeping in own bed with lights on and favorite stuffed animal for one night.'' In CBPT, the child would be helped to complete each task using modeling (e.g., puppet or therapist goes first).

Systematic Desensitization. Systematic desensitization is the process of reducing negative emotions by replacing a maladaptive behavior with an adaptive one (Wolpe, 1958, 1982; Ollendick & King, 1998). This is accomplished by breaking the association between a particular stimulus and the negative emotion that it usually elicits. The stimulus is presented, but the negative emotion is prevented from occurring. Systematic desensitization involves the person imagining a hierarchy of emotionally charged scenes in combination with these incompatible responses. This technique can be modified for children by using developmentally appropriate tasks to aid in relaxation (e.g., Cautela & Groden, 1978). With children in CBPT, other methods to induce relaxation are calming play activities and visualization of calming scenes.

Contingency Management. Contingency management is a general term referring to techniques that modify a child's behavior by controlling its consequences. Positive reinforcement and shaping are the most common forms of contingency management, both of which can be integrated into the CBPT approaches. First, positive reinforcement is an important component of CBT and is used by specifying a target behavior, determining a reinforcer, and making the reinforcement contingent on the occurrence of the targeted behavior. Positive reinforcement often involves social reinforcers (e.g., praise) or material reinforcers (e.g., stickers), and it can be direct (e.g., praising the child with separation anxiety for venturing off to school without mom) or more subtle (e.g., reinforcing independent play, which ultimately would lead to more confidence in the ability to be away from a parent figure). Shaping is another method of contingency management and helps a child get closer and closer to a targeted goal. The child is given positive reinforcement for closer and closer approximations to the desired response. Eventually, the child reaches the desired behavior. The child is not expected to master all the skills at once to achieve the desired response.

Stimulus Fading. Stimulus fading may be used if the child has some skills, but exhibits them only in certain circumstances or with certain people. The therapist will help the child transfer these skills by gradually fading out the situation where or the person with whom the child is currently able to exhibit the behavior. For example, a child who is able to separate from his father when a babysitter comes to the home, but not from his mother, may initially have only the father home when the babysitter arrives. The mother would be gradually faded back into the ''transition to babysitter'' routine.

Extinction/Differential Reinforcement of Other Behavior (DRO). Sometimes children's maladaptive behaviors are inadvertently being reinforced. If the maladaptive behavior is to stop, the reinforcement must be removed. A common reinforcer is parental attention, for example when a parent inadvertently reinforces a child for whining and crying by paying a lot of attention to the child when she/he is crying. When reinforcers such as attention are withheld, the behavior is ignored, resulting in the undesirable behavior decreasing or disappearing (i.e., extinction). However, extinction does not teach new behaviors, so it is often used in conjunction with reinforcement, where a more adaptive behavior is reinforced (DRO) while the maladaptive behavior is extinguished. Often, the alternative (other) behavior is incompatible with the undesired behavior (e.g., when a child is playing calmly and safely, he can't also be hitting and breaking things).

GENERALIZATION AND RELAPSE PREVENTION

Braswell and Kendall (1988) noted that children often made gains in CBT, but they failed to generalize and maintain these gains after the completion of therapy. More recently there has been growing attention to the need for the therapist to be mindful of generalization, helping the child generalize what is learned in therapy to other settings such as home and school. Because adults often play an important role in a child's life, their attitudes and behavior toward the child can influence such generalization of adaptive skills learned in therapy. For example, if parents, teachers, day care providers, and others support and reinforce the child's new adaptive skills, these skills are more likely to be used in other settings. Additionally, therapy should be designed to promote and facilitate generalization, rather than assuming it will occur naturally. Thus, part of treatment should include helping the child develop skills that will occur at home, school, and elsewhere, and not just in the play therapy office.

The therapist should use interventions that address generalization directly and are as similar as possible to real life situations (e.g., creating play scenarios with settings and people similar to the ones in the child's life). The significant adults in the child's life should be involved in treatment (e.g., trained to use appropriate reinforcement of adaptive behaviors and extinction of maladaptive ones). CB interventions that promote self-control of behavior will help the child generalize, so that his/her behavior is not completely other driven. Finally, interventions should continue past the initial acquisition of skills to ensure that the child has had an adequate opportunity to learn more adaptive skills.

Relapse prevention is another important component of CBT and involves both consolidating cognitive and behavioral techniques and decreasing reliance on the therapist (Velting, Setzer, & Albano, 2004). Therapists should work to highlight the key techniques that were effective in allowing the child to overcome difficulties. In CBPT, this can be done by making a book of lessons learned. The therapist can encourage both the parents and the child to review the book if and when the problem resurfaces.

Although setbacks are part of learning any new skill, children and parents should be helped to understand how they can cope when such setbacks occur. Treatment should take the possibility of setbacks into account and address this issue directly, thereby preparing both the child and parents for what to expect and what to do in certain situations that can be helpful. High-risk situations are identified as things that might present a threat to the child's sense of control and ability to manage. For example, a socially shy child, who is managing well in a small kindergarten classroom, might be helped to understand that when he moves to a new, larger first-grade classroom, the situation may become challenging.

TERMINATION

Ideally, it is recommended that therapy termination occurs as a gradual process, so that preparation for completion of therapy takes place over several sessions. The child should be prepared for the concrete reality of termination (e.g., "You will only be coming in for X sessions and then we will be saying goodbye.") as well as the feelings that may accompany the end of treatment. It is common for children to have conflicting feelings about the end of treatment. Such feelings may be addressed directly by the therapist (e.g., ''It seems like you may be a little sad that we won't be meeting anymore'') or indirectly (e.g., ''Some kids tell me that they feel sad when they stop coming to therapy''). Some children may benefit from hearing the therapist model an appropriate emotion related to the end of therapy (e.g., ''I will miss seeing you, but I will feel happy knowing that you are doing so well''). The CBP therapist can confirm for the child that he/she is important and it is okay to have feelings about termination (e.g., ''I will miss you too,'' ''The puppets will miss you, but we are all happy to know you are doing so well'').

Younger children often benefit from some type of concrete representation of the end of treatment (e.g., a construction paper chain with each link representing a therapy session until the last one). Older children may understand a calendar, marked with the final therapy session. These concrete reminders may also provide visual aids that help the child talk about affect related to the end of therapy. Some children are also helped by a concrete transitional object, such as the therapist's business card (with name and phone number), or a picture the child draws for the therapist that he/she sees is being kept in a special place in the therapist's office.

Oftentimes, the final sessions are tapered, so that, rather than meeting weekly, the therapist may meet the child biweekly or monthly for a period of time. These intermittent appointments may serve to communicate to the child that she/he can manage without the therapist. This is often supplemented with positive reinforcement from the therapist regarding how well the child is doing between sessions. Sometimes, these appointments are scheduled over a period of time, as part of the phasing out. Other times, they are intermittently scheduled with a particular event in mind (e.g., the beginning of the school year, a family move, parent remarriage). For example, a child who is doing well, but who has some concerns about moving to a new home, may be seen intermittently until after the final move takes place.

It is important for the child to understand the end of therapy as a positive rather than a negative event. The therapist should identify and praise the child's accomplishments in therapy (e.g., working hard, talking about difficult feelings). If she/he feels that bad behavior or problems will prompt a return to therapy, the child may act out to see the therapist again. In addition, the therapist should normalize the experience of saying goodbye to significant relationships by talking about examples in the child's life (e.g., friends at the end of camp, teachers at the end of the school year). Reassurances, and suggestions for keeping in touch can be helpful. Children often like to hear that the parents will keep in touch with the therapist or that the child can send the therapist a picture or card. Describing an open-door policy, particularly that it is acceptable to return to see the therapist even if things are good, may help the child understand that the therapist still cares, even if the child is not coming in regularly.

Finally, a termination party or celebration, scheduled for the final session, provides a concrete bridge between therapy and termination. Involving the child in the plans (e.g., Who will be invited? Which puppets? Parents? Just child and therapist? Should we make decorations?) is useful. The main purpose of this event is to celebrate the positive gains made in therapy, emphasizing the child's self-control and mastery of self-help skills. It is appropriate to provide the child with a small, symbolic token of these gains (e.g., a certificate or small puppet like one that helped the child most in treatment).

PARENT INVOLVEMENT IN CBPT

Parent involvement is important throughout assessment and treatment with CBT approaches (Stallard, 2006). Initially, much of the assessment information is gathered from parent report, rating scales, and observations of the child. After the assessment is completed, a meeting should be scheduled with the parents to present findings and agree upon a treatment plan. When CBPT is recommended (as opposed to focus solely on parent work), typically there is some therapeutic work involved with the parents. Decisions about how much to include the parents are based on the therapist's assessment of many factors. One factor that relates to the amount of help the family may need in modifying their interactions with the child is the frequency with which parent behavior serves to encourage, reinforce, or exacerbate a child's behavior. Another factor, the amount of assistance the child might need in implementing a treatment plan outside of therapy, is directly related to the need for interventions outside of therapy, such as exposure tasks (e.g., for a fearful child), modeling positive self-statements related to the child's progress, or aiding in the problem-solving process outside of therapy.

Even when the work is primarily with the child, it is important to meet with the parents on a regular basis. This time can be spent gathering information about the child's progress, monitoring and intervening in relation to the parents' interaction with the child, and making suggestions related to areas of concern.

TROUBLESHOOTING/COMMON PROBLEMS AND HOW TO HANDLE THEM

There are many challenges that face the CBP therapist. Common problems include, but are not limited to, children:

- who are shy or have separation issues (e.g., won't leave parent in waiting room)
- who present a different perspective on how things are going than their parents do
- who are upset by the therapist's time with their parents

THE CHILD WHO IS SHY OR DOESN'T WANT TO SEPARATE FROM THE PARENTS

Oftentimes, children will refuse to separate from their parents to accompany the therapist to the play therapy room. Children may become tearful, cling to their parent(s), or ignore the therapist. This may be due to shyness, anxiety, or selective mutism. The therapist should be sensitive to these issues and realize that the child may be emotionally overwhelmed. When this occurs, the therapist should begin the session with the parent or parents in the therapy room and, once the child becomes comfortable, gradually phase out the parents from the room (i.e., shaping). For instance, at the first session, the child, therapist, and parents can play a game together. When the child is ready the parent can stand outside the room with the door open and the child can continue to play with the therapist as the parent watches. Next, when the child agrees to closing the door, the therapist and parent inform the child that the parent will be right outside. With some separation anxiety cases, this phase-out process may take several sessions.

THE CHILD WHOSE PERCEPTION OF HOW THINGS ARE GOING IS DIFFERENT FROM THE PARENTS

Sometimes children report a situation that is quite different from what the parents are reporting. Most often, this is when a child reports that some aspect of life is fine, but the parents do not view it this way. For example, a child who says she has no difficulties separating to go to school is, in fact, crying on a daily basis about separating from the parent. It is important to understand the fantasy content of a child's report. Many times the child is expressing how he/she wishes things were or how they feel it should be rather than how it actually is. One can acknowledge the fantasy ("I know you would really like to be able to leave mom and go to school without crying''). The therapist can also use the information to help reframe what the child is saying and help him/her strive for the goal (''It sounds like you really want it to be that way, so we will keep working toward you leaving mom without crying'').

THE CHILD WHO IS UPSET BY THE THERAPIST'S TIME WITH PARENTS

Sometimes children are upset by a therapist's time with the parents. The therapist can help the child by labeling feelings about this (e.g., ''It seems that you get angry when I have to meet with your parents''). It can also be helpful to confirm the reasons for the meetings (e.g., ''I know it is hard, but it is important that I meet with your parents. I want to be able to help the whole family, and your parents need time to talk to me too.''). Stressing confidentiality is important, while reminding the child that the parent-therapist session is not used to repeat what the child has discussed (e.g., ''Remember when we talked about how this was your own special time with me, and that I wouldn't repeat things we talked about to your parents? I wonder if you are worried that I might say something to them that you don't want me to say? I won't tell them what we talked about.'').

CASE DESCRIPTION

The following case description was selected to illustrate the use of CBPT for two comorbid concerns. Lisa was an eight-year-old female of Chinese descent who was adopted as an infant and brought to live in a large city in the United States. Her adoptive parents were both Caucasian and told Lisa of her adoption when she was a toddler. Lisa presented with animal phobia and sadness about her parents' separation. Specifically, she experienced intense fears about pigeons and was unable to walk near them. If a pigeon landed even 500 feet away, Lisa ran quickly across the street without warning. Her parents worried that she would get hit by a car one day. In addition, her worries limited their family outings, because they were unable to visit parks or open areas in the city where there were pigeons. In addition, Lisa's parents were married for 10 years and had separated about two years ago, when Lisa was six years old. Her parents lived in separate homes and had a visitation agreement that split Lisa's time between the parents. Although both parents reported that she seemed to be a happy child, she was sad when reminded about the separation. She became tearful when transitioning from one home to another and when saying goodbye to either parent.

COURSE OF TREATMENT

Lisa was seen for 11 sessions of CBPT over the course of four months. In the assessment phase, a combination of parent report, child self-report, and behavioral observations were used to determine whether CBPT would be an effective treatment approach for this case. Parents were seen for a clinical interview to obtain history and background information, which indicated that her symptoms were consistent with a specific phobia, animal type, and there were adjustment concerns. Based on the parent and child report, Lisa enjoyed playing and had more than 100 stuffed animals in her room, with her favorites being Puppy (i.e., very old dog) and Piglet (e.g., furry pink pig). Also, her cognitive and social skills seemed to be better developed than children her age. Parents reported that she achieved high grades in school and was highly verbal. In the therapy room, Lisa presented as articulate and responded appropriately to questions. Lisa reportedly had many friends, but she confided only in one friend about her feelings related to her parents' separation. In the initial session, the therapist experienced Lisa as friendly and easily able to engage. Behavioral observations of Lisa's play suggested that she was comfortable playing with the therapist, but her level of emotional expression in play was low. In general, Lisa was considered a good player from unstructured assessment suggesting age-appropriate cognitive, emotional, and social skills.

Treatment goals were to build skills to manage her anxiety related to pigeons and to manage her emotions around parental separation. Addressing the anxiety about pigeons was chosen as the primary goal in collaboration with the parents. The rationale was that using a skill-building approach would increase Lisa's ability for emotional expression in play. These skills could be generalized and applied to feelings about the separation. Additionally, the animal phobia was a more discrete problem than the complex issues involving her parent's marital status. The initial stages of treatment involved skill building, with the final treatment sessions including exposure to pigeons, as well as dealing with the sadness around the family break-up. Throughout therapy, methods of delivering CBPT included modeling and structuring sessions, and techniques included psycho-education, relaxation, cognitive restructuring, exposure, and systematic desensitization using her stuffed animals and worksheets.

During skill building, Lisa was provided psycho-education on emotions as a technique to develop labels for her different emotional experiences. She and the therapist read ''How Are You Peeling?'' (Freyman & Elffers, 1999), a children's book that illustrates different vegetables expressing different emotions. Lisa was asked to describe what the different emotions feel like to her. Then, she was instructed to identify the five most common feelings she had, which were placed on a feelings chart. Lisa and her mother agreed to select and describe a feeling on the chart each night. Over the next few sessions, Lisa was asked to bring her favorite stuffed animals, Puppy and Piglet, who became part of the teaching of relaxation, cognitive restructuring, and positive self-statements.

First, Lisa was taught to do deep breathing as a technique to calm her body when sad or nervous. Both the therapist and the stuffed animals did the breathing with her. Then, cognitive restructuring was introduced as ''helpful thinking,'' a technique that helps kids to change their negative thoughts into positive thoughts. Worksheets with thought bubbles for animals and therapist modeling of the use of questions were implemented to develop positive self-statements. Also, the importance of positive self-statements was described by using worksheets that contrasted the emotional experiences between ''helpful'' and ''unhelpful'' thinking.

An anxiety management plan (i.e., ''Calm Down Plan'') was developed by integrating these techniques, with the purpose of implementing the plan for exposure tasks. Exposure was used to help Lisa be in contact with the anxiety-producing stimuli while coaching her to use her skills so that her anxiety could decrease over time. The ''Calm Down Plan'' included two steps: (a) Take a deep breath; (b) Say helpful things to myself like ''Pigeons are gentle;'' ''I'll be okay;'' and ''Mom and dad will scare them away. '' A fear hierarchy consisting of a low-level anxiety task to high-level anxiety tasks was developed, which was explained to Lisa as a ''list of tasks to help you feel more comfortable around pigeons.'' Lisa listed a total of 10 tasks, which were determined by rating each task on a scale: 1 (low anxiety) to 10 (high anxiety). These tasks, from lowest (1) to highest (10) were:

Reading facts about pigeons
Seeing a hand-drawn picture of pigeon
Touching a hand-drawn picture of pigeon
Seeing Internet picture of single cartoon-like pigeon
Seeing Internet picture of single pigeon that looked real
Touching Internet picture of single pigeon that looked real
Seeing Internet picture of a flock of pigeons that looked real
Touching Internet picture of a flock of pigeons that looked real
Standing across the street from a live pigeon
Standing 100 feet from a live pigeon while holding parent's hand

Using a CBPT approach, each task was completed using concepts of modeling and exposure. Stuffed animals were used as the play medium, and the child was an active participant by choosing tasks throughout. At the beginning of each session, Lisa, along with Puppy and Piglet, were asked to decide her readiness for one to two tasks. Lisa and the stuffed animals were asked to rate their anxiety level before, during, and after the task. For example, when she was ready to touch pigeon pictures on the computer screen, the therapist first touched the picture, then held Lisa's stuffed animals while they touched the picture, and finally asked Lisa to touch the picture. The therapist talked throughout and coached Lisa to use the ''Calm Down Plan'' when her anxiety increased above ''5.'' After a few sessions, Lisa was able to touch pigeon pictures while maintaining her anxiety in a low to moderate range (i.e., less than ''5''). In general, she reported her anxiety level decreased around pigeon pictures.

Both Lisa and her parents agreed she was ready to begin the tasks involving live pigeons during the week. They chose to do the tasks naturally rather than planned. This meant that, whenever a pigeon flew near them, mother or father prompted Lisa to do the ''Calm Down Plan'' until her anxiety was below a ''5.'' Parents stated that, because it was spring, the family was outside often and would explore parks to increase chances of seeing pigeons.

Upon completing the exposure tasks, Lisa then engaged in CBPT techniques to better manage her feelings of sadness around parental separation. Initially, Lisa was comfortable with pretend play using her stuffed animals, but she was reluctant to discuss her thoughts and feelings about her parents' situation. She stated that she talks with her stuffed animals at night and friends at school but that what she told them was private. Psycho-education of emotions was reviewed and bibliotherapy used to normalize her thoughts and feelings (e.g., ''not your fault''). Afterward Lisa was better able discuss her disappointment when first told about the parents divorcing and her ongoing desires for her parents to reconcile. The stuffed animals were used to challenge negative cognitions and to form positive self-statements. For instance, Puppy would say to Piglet, ''What are some things that we know are true about my relationship with mommy and daddy?'' Piglet would respond, ''We know that mommy and daddy still love me.''

TREATMENT OUTCOME

Improvements in Lisa's coping skills for anxiety and sadness were noted. Both parents reported that she was better able to tolerate anxiety when a pigeon was nearby or approached her. If she became anxious, instead of running across the street, she would allow her parents to coach her to use the Calm Down Plan and/or ask to find a safe distance from the pigeon. In addition, Lisa also expressed neutral feelings when transitioning from one parent's home to another. Thus, termination was discussed and agreed upon. Despite a more gradual and planful end of therapy, Lisa's termination was abrupt, because the parents decided to take a break for the summer. At the final session, Lisa was provided relapse prevention, which involved consolidating cognitive and behavioral techniques in a concrete way and as a summary for quick reference. This prepared Lisa and her parents to independently manage setbacks and decreased reliance on the therapist. Specifically, Lisa was asked to make a note card with the steps of the Calm Down Plan and a list of future anxiety-producing events for which the plan could be used. It was recommended to the parents that they ''coach'' Lisa to use the summary to manage anxiety in general and future triggers for anxiety.

FOLLOW-UP

Three-month follow-up included a phone session and rating scale completed with Lisa's father. In general, father reported that Lisa continues to use her ''Calm Down Plan'' when she sees pigeons. However, he noted that the anxiety management plan is more effective for one pigeon rather than flocks of pigeons. Father also described continued improvements in transitioning from parents' homes, in that the crying and reports of sadness are absent.

QUALIFICATIONS FOR COGNITIVE BEHAVIORAL PLAY THERAPISTS

Cognitive behavioral play therapists should be professionally trained, with appropriate coursework, clinical training, and degrees in a relevant discipline (e.g., psychology, social work, psychiatry). Child development, psychopathology, assessment, psychotherapy, and family systems should be a large focus of the individual's coursework. Individuals who are competent to work with older children will need more specific training in play therapy and working with younger children. Therapists should also be well versed in CB theory and practice and should be comfortable in adapting these for use with children. In addition to a thorough understanding of the literature, the CBP therapist should have supervised experience. Ideally, live or videotaped observations of CBPT sessions should occur. Given the limited number of CBP therapists, clinicians in training will need to stay current with the growing body of literature on CBPT and utilize sources such as graduate programs, national conventions, and play therapy associations (e.g., Association for Play Therapy) and continuing education training programs.

SUMMARY AND IMPLICATIONS FOR PRACTICE

CBPT is novel approach that allows the therapist to combine empirically supported cognitive behavioral techniques within a play paradigm. CBPT is appropriate for preschool and early school-age children. With this approach, the child is helped to become an active participant in change (Knell, 1993). The therapist facilitates this by presenting developmentally appropriate interventions. Many cognitive and behavioral interventions can be incorporated into CBPT, in that treatment is structured and goal directed, but allows the child to bring spontaneous material to the session. The balance between spontaneously generated and more structured activities is a delicate one, though both are critical. The former provides a rich source of clinical information, and the latter a mechanism for modeling more adaptive coping skills.

The initial stage of CBPT, assessment, is an important component of the therapeutic process. Critical information about the child is gathered using a wide array of assessment methods, ranging from parent interview to play assessment. In CBPT, play materials are also used as models to communicate more adaptive coping skills and behaviors. Historically, puppets and other toys have been used in assessment and play therapy as a means of communication with young children. Although there is a growing literature on CBPT, the present chapter provides a more hands-on approach. Treatment involves modeling, role-play, and structuring, as well as the implementation of a wide range of cognitive and behavioral interventions. Throughout the chapter, examples are provided so that the actual implementation of CBPT can come alive for the interested therapist.

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CHAPTER 17

Play Therapy Techniques for Affect Regulation

SUSAN TRACHTENBERG PAULA

TO THE UNINITIATED, it may look like Hector and his therapist are just playing. But Hector and his foster mother understand that Hector's therapist is working in a very structured way to help him control his emotions and his behavior more effectively. Hector's therapist is a cognitive behavioral play therapist. When Hector comes to his session, his therapist selects games and activities that specifically address Hector's difficulties and build skills that he lacks or needs to improve. Last week, Hector and his therapist played *Simon Says,* and Hector found it frustrating but fun. His therapist knew that the game would require Hector to inhibit his impulsive responding. To play *Simon Says* well, Hector would have to listen and look before acting. He would also have to manage the emotions that might come along with such a game, such as excitement, frustration, or disappointment.

Hector is working on managing his emotions through participating in cognitive behavioral play therapy. In this, the therapist does an assessment of the child's strengths and areas of need, develops treatment goals with the child and his or her family, selects activities that will allow her to achieve these goals, and then gets down to the work of playing.

Throughout this chapter we'll look at play therapy strategies for young children, school-age children and adolescents. Let's consider three children of these ages. First, let me introduce you to Hector and his sisters.

Ten-year-old Hector lives in a foster home with his two sisters, Jasmine (15) and Jessica (6). Five years ago, they were removed from their mother's care after a preschool teacher noticed bruises on Hector's buttocks when she was helping him get dressed after using the bathroom. After social service workers interviewed the three siblings and their teachers, they visited Hector's home to speak to his mother. They determined that Hector and Jasmine had been repeatedly physically abused by their mother. All three children had also witnessed many violent episodes between their mother and her boyfriend.

Hector and his sisters were fortunate in being placed with skilled and patient foster parents who have taken care of them for the last five years of their lives. Mr. and Mrs. Vega are committed to caring for the three children, but are quite concerned about them. They report that Hector can suddenly become angry and aggressive, seemingly for no reason. He also has difficulty falling asleep, and sometimes gets no more than one or two hours of sleep a night. When he does fall asleep, he often has nightmares about monsters and vampires.

The Vegas have concerns about Hector's sisters, too. Fifteen-year-old Jasmine seems to be too sad and anxious for a girl her age, and she is very hard on herself when she doesn't do well in school or when she makes even a small mistake. Yesterday, Jasmine dropped a glass of milk on the floor. Mrs. Vega didn't have the heart to yell at her because Jasmine started calling herself stupid and clumsy, and even hit herself in the head three or four times. The Vegas would like Jasmine to be easier on herself and less sad and nervous.

Mr. and Mrs. Vega report that they worry about six-year-old Jessica's activity level and difficulty concentrating. Jessica is always on the go, always reacting to noises she hears, and can't seem to stay with any one activity for very long. She also has a very strong startle response and jumps and gets upset when she hears loud voices.

Hector and his siblings are all manifesting the signs of affect dysregulation, probably as a consequence of their exposure to the frequent violence between their mother and her boyfriend, and for the two oldest children, their own physical abuse. Children exposed to violence often have difficulties managing their extreme emotions and rapid emotional shifts. Fortunately, many cognitive behavioral play therapy techniques are available to help them identify and cope with their extreme and often frightening emotions.

WHAT IS AFFECT DYSREGULATION?

DEFINITIONS

The Complex Trauma Workgroup of The National Child Traumatic Stress Network (2003) defines affect dysregulation as ''(a) deficits in the capacity to identify internal emotional experience, (b) difficulties with the safe expression of emotions, and (c) impaired capacity to modulate emotional experience'' (p. 12). Like Hector, children who have difficulty regulating their emotions can be explosive and have unpredictable episodes of out-of-control behavior. They may also have difficulty going to and staying asleep. Like Jasmine, they may become extremely sad or anxious, and may engage in self-harming behavior when they are overwhelmed by their feelings. Like Jessica, they may have difficulty managing their level of activity and have difficulty concentrating and performing well in school. Affect dysregulation often accompanies anxiety disorders such as generalized anxiety disorder and posttraumatic stress disorder, mood disorders such as depression and bipolar disorder, and disruptive disorders such as oppositional defiant disorder (Bradley, 2000).

Children who have difficulty regulating affect are a study in extremes. They become very distressed very quickly and have great difficulty calming themselves down. For example, Hector's special education teacher reports that Hector often becomes enraged at even the smallest things in class. She described an incident in which Hector tried to stab a classmate with a pencil after the classmate accidentally knocked into him while passing by. After this incident, the teacher reported that Hector seemed completely unable to calm himself down. Two staff members had to stay with him for over an hour and a half until he was able to return to his classroom.

Hector's older sister Jasmine displays her dysregulation in quite different ways. Jasmine tends to hurt herself when she becomes distressed. She often hits herself in the head, and on several occasions has cut her forearm with the edge of a paper clip. Jasmine says that this behavior helps her cope with intense emotions that she ''doesn't know what to do with.'' Jasmine reports that she feels better when she hurts herself.

By contrast, six-year-old Jessica's dysregulation manifests as hyperarousal and hypervigilance. She reports that she ''doesn't feel right'' when she's sitting still and feels better when she's running around. She also has an extremely strong startle response and jumps whenever she hears loud voices in the street, in other classrooms, or from other apartments in her building.

Assessment

Treatment goals will be determined by the client's strengths and areas of weakness, and these can be assessed during the early stages of play therapy. The therapist should look for the child's functioning in the following areas:

1. Range and intensity of emotions. Does the client show a wide range of emotions, both positive and negative, and how intense are these emotions? The therapist will want to focus on teaching the client to express emotions that aren't being expressed and modulating emotions that are expressed so intensely or inappropriately that they interfere with social and academic functioning.
2. Ability to label emotions or use feelings language. Is the client able to talk about feelings and accurately label the feelings that he or she is experiencing? Skinner and Zimmer-Gembeck (2007) offer evidence that the use of emotional language is a mediating factor in the ability to effectively cope with stress. The ability to recognize one's own emotions is also an important factor in coping. Children will have to learn to understand that they are feeling distress and label it as such before they can engage in active coping.
3. Ability to connect emotions to trigger events. Does the client know the emotional reactions they have to different external and internal emotionally triggering events? Helping children understand the connection between their emotional reactions and the situations or thoughts and beliefs that cause them is one goal of play therapy aimed at increasing a child's ability to manage emotions.
4. Use of coping strategies. Does the child already have strategies for coping with overwhelming emotions, and how adaptive are those strategies? Information about coping will largely come from the therapist's observations during play. The therapist should pay attention, for example, to whether the child takes a deep breath or uses coping self-statements before approaching a difficult task, does anything to alleviate physical tension when discussing difficult material, or asks for help from the therapist when he or she needs it. Alternatively, does the child try to avoid negative emotions or begin to act out when feeling overwhelmed? Many children may cope effectively in some situations, and the therapist can help them learn to transfer the use of those effective strategies to situations in which the child doesn't cope as effectively. In addition, children may be using maladaptive coping strategies such as avoidance, acting-out, self-harming behavior, or substance abuse to cope with overwhelming emotions. It is often helpful to label those behaviors as coping strategies, albeit ineffective ones, so children can understand that they will be working on finding more adaptive alternatives.

5. Perception of sense of control over emotions. Does the client feel at the mercy of her emotions, or does she feel a sense of being able to control them? Many children with affect dysregulation report that they are frightened by their feelings and their inability to control them. Giving clients a sense of control over their emotions will be another goal of play therapy.

STEPS FOR USING COGNITIVE BEHAVIORAL PLAY THERAPY TO ADDRESS DYSREGULATION

Using Treatment Goals to Focus Play

Many therapists new to cognitive behavioral play therapy question the possibility of achieving significant therapeutic change through play. Cognitive behavioral play therapy can be a highly effective and efficient means of producing improvement in children's ability to manage their emotions. The modality recognizes and adapts to children's limited capacity to express their feelings and thoughts verbally. By not limiting the work to exclusively verbal interactions, the therapist has greater access to clients' thoughts and feelings about their world and their difficulties.

By working through play, the therapist also has a potentially greater impact on the child's functioning and dysregulation. Cognitive behavioral play therapy's emphasis on doing, rather than talking, allows clients to practice all the new skills they have learned and to generalize them to their lives outside the play therapy session.

To faciliate this transfer, treatment goals are essential. It is important that the play therapist always be aware of their clients' treatment goals and always look for opportunities to work on those goals through play. This helps in assessing treatment progress in managing dysregulation. The therapist can use play to teach new skills, model the use of the skills, and help the child practice and refine those skills, almost no matter what activity, game, or pretend play scenario the child is engaging in.

The therapist may sometimes want, however, to limit the choice of game or play activity to those that will specifically elicit problems with dysregulation. Choices may include frustrating board or card games, games or sports that involve losing, and pretend play scenarios that closely resemble situations that present difficulties for the child. The therapist should spend time carefully choosing the play materials and situations that are most likely to lead to the accomplishment of therapeutic goals.

AFFECT IDENTIFICATION

Before we can cope effectively with emotional distress, we must recognize that we are experiencing an emotion and be able to label that emotion. A simplified version of the process goes something like this: First, we receive a signal from our bodies that tells us that we are distressed. For some people, it's their neck or shoulders that become tight, others get butterflies or tightness in their stomachs, others notice a quickening in their breathing or heart rate, while still others notice that they have clenched fists.

Next, we interpret our bodies' signals. The decision about how to interpret these signals often depends on context. If I'm standing on top of a high mountain looking down and my stomach is churning, I would almost certainly interpret my feelings as fear. Sometimes, though, the decision is based on what we might have been thinking about at the time. We might say, ''My heart is beating faster, and I was just thinking about all the work I have to do today. I must be anxious.''

Next, we engage in a coping skill that relieves our distress. The first step—identifying our emotions—is crucial. Without it, we wouldn't be able to choose an effective strategy for coping with our distress. For people who cope well, the process is often below awareness. We don't notice that we've scanned our bodies, assigned meaning to our reactions, taken a deep breath, made a coping self-statement, or relaxed a tense muscle. When the use of coping skills is well practiced, it can seem to happen automatically and without much effort.

Many children and adults who don't cope well need to be taught the process step by step. The first step is helping clients become aware of the physical manifestations of different emotions. Next is helping clients learn to accurately interpret their emotions. Finally, we help clients understand what external and internal events trigger different emotions.

It's important to be aware that a child's ability to understand emotions is somewhat dependent on their age, level of cognitive development, and whether they have learning disabilities. Carroll and Steward (1984) found that older children are more likely than younger children to describe feelings as an internal rather than a situational experience, to understand having more than one feeling at a time, and to believe that they can change their feelings. Younger children will find it easier to understand and talk about simple emotions (happy, sad, scared, mad) that are elicited by external events. Although children under about age seven experience multiple emotions simultaneously, they will have great difficulty understanding and talking about their multiple emotions, and it's not until about age 10 that children understand the concept of ''mixed feelings'' or holding two contradictory feelings at the same time. Bauminger, Edelsztein, and Morash (2005) showed that children with learning disabilities may be delayed in their emotional understanding.

STRATEGIES FOR BUILDING AFFECT IDENTIFICATION

Strategy 1: Labeling Feelings. A wide variety of emotions will naturally be elicited during play. Children may become excited, frustrated, angry, or happy in the course of pretend play or game play. Therapists can use their clients' and their own naturally occurring emotions to help children become aware and increase their understanding of emotions. The simplest approach is to label feelings for the client: label your own feelings, label your clients' feelings, label the feelings of dolls, puppets, action figures, dinosaurs, and any animals that come up in pretend play. Some therapists may be hesitant to label their clients' feelings because they feel uncomfortable ''telling their clients how they feel.'' This is a legitimate concern, but labeling feelings can be very helpful for children and adolescents who aren't able to identify or understand the emotions they're experiencing. Based on prior knowledge of the client and observation of context (i.e., what the child was talking about or playing), therapists should feel comfortable taking an educated guess about the client's emotions.

In his therapy sessions, Hector's therapist labels both positive and negative feelings expressed during pretend play situations. Hector particularly likes to play with superhero figures, so the therapist labels the feelings of the figures during play. For example, when two superheroes are engaged in a battle, the therapist will label the figures as angry, frightened, ashamed, or cruel, as dictated by the play situation, and connect the situation to the feeling it evoked.

Strategy 2: Connecting Feelings and Their Physical Manifestations. Before children can cope effectively with their feelings, they must recognize them by correctly interpreting the signals their bodies send them. The next step in building children's ability to cope with feelings, therefore, is to help them correctly identify the physical manifestations of different emotions. As discussed above, games and pretend play naturally elicit a wide range of emotions that can be connected with their physical manifestations. Children's bodies will often react differently to excitement, anxiety, fear, anger, and frustration.

To illustrate, let's consider frustration, an emotion that many affectively dysregulated children often have difficulty managing, and one that occurs frequently when children play games. To help clients connect the emotion frustration with its physical manifestation, therapists can talk about their own physical reactions to frustrating games and then ask their clients to pay attention to how their own bodies feel during the game. My favorite frustrating game is *Operation* because it is difficult to play and because it is both emotionally and physically arousing. The game is difficult because players have to remove plastic body parts (broken heart, wrenched ankle, funny bone, etc.) from narrow slots in the game board with a metal tweezer. The game is arousing because if the metal tweezer touches the edges of the narrow slot, a loud and annoying buzzer sounds.

This game provides the opportunity for the therapist to model identifying emotions from their physical manifestations. For example, the therapist might talk about knowing that he feels nervous and tense because his stomach feels as if it's in knots while he tries to get the piece out, and when the buzzer goes off, he knows that he feels annoyed and disappointed because his chest and shoulders get tight. To help children identify where in their bodies they experience different emotions, the therapist might walk their clients through a scan of their bodies to identify where they are experiencing distress:

1. How does the child's head feel? Is there tension, a headache, racing thoughts, and so on?
2. How does the child's face feel? Have the child look in a mirror to observe a furrowed brow, clenched teeth, and so on.
3. How do the child's neck and shoulders feel? Are the shoulders drawn up around the neck, does the neck feel tight or hurt, and so on?
4. Is the child's heart beating faster? You can have the child put her hand on her chest to feel how fast her heart is beating.
5. Is the child's breathing faster, deeper, shallower? Have the child feel how deeply or quickly she is breathing.
6. Are the child's fists clenched? Have the child look down at her clenched fists.

This strategy would be appropriate for preschool, school-age, or adolescent clients. When she is working with Hector, his therapist uses frustrating games such as *Operation* or *Sorry* because Hector has particular difficulty managing frustration and disappointment. The therapist helped Hector discover that his stomach hurts and that he clenches his fists and jaw when he feels frustrated. When the therapist works with Hector's teenage sister Jasmine, who has difficulty managing her anxiety, the therapist helps Jasmine notice that her palms become sweaty and her breathing rate increases when they play chess and Jasmine isn't sure which move to make. When the therapist works with six-year-old Jessica, she uses this strategy as a first step in working with Jessica to reduce her hyperarousal. Whenever Jessica becomes upset she engages in seemingly aimless, frantic motor behavior. This occurred during one session while Jessica and the therapist were playing with the dollhouse and doll family. Jessica had the father doll hit and kick the mother doll, and she became agitated and seemingly manic. Jessica's therapist instructed her to feel how fast her heart was beating and to try to make it slow down. Not only did Jessica begin to make the connection between her body's signals and her distress, she also found that putting her hand on her heart made her feel calmer and distracted her from the distress she was feeling.

Strategy 3: Using Imagery to Increase Emotional Understanding. Rather than involving naturally occurring emotions, this strategy elicits specific emotions by having children imagine how they would feel in different situations. Avoid situations that are likely to arouse intense emotions and instead focus on those that elicit only mildly to moderately strong feelings. For example, the therapist can induce feelings of excitement (Christmas morning, the day of the child's birthday, etc.), calm relaxation (reading a favorite book or watching a favorite TV show), and anxiety (waiting to take a test). Children are likely to benefit most from this activity the more fully they can be absorbed in the imagery. Here's an example:

> Get comfortable in your chair, and if you feel like it, you can close your eyes. Let's imagine it's the morning of your birthday and you've just woken up. You don't realize right away that it's your birthday, but then all of a sudden you remember. Keep your eyes closed and really feel like you're in your bed. First, tell me what you would be experiencing (prompt child for physical sensations, paying attention to the smells, sounds, sights the child would experience lying in bed). Next, tell me how your body is feeling. Tell me how your head feels . . . next your forehead . . . next your mouth and jaw . . . next your neck and shoulders . . . next your chest . . . next your stomach. . . . (This level of prompting isn't always necessary, but some children may need it to ensure that they are attending to all areas of the body that may be involved in the emotions elicited.) Next, tell me what thoughts are going through your head. (Asking about thoughts will help the therapist more accurately label the child's emotions and point out the connection between the emotions and their physical manifestations.)

When 15-year-old Jasmine's therapist did this exercise with her, she had an especially intense reaction to imagining that she was waiting to take a test. She reported that she got butterflies in her stomach, that her heart started to race, and that she had thoughts of running away. Jasmine and her therapist now have a better idea of what happens physically and cognitively to Jasmine when she becomes anxious.

Strategy 4: Identify Emotional Triggers. Children are better able to manage their emotions if they are aware of the events that typically trigger them. Emotional triggers can be external events, such as situations or occurrences that elicit strong emotions. Hector and his sisters, for example, all report that the sound of adults arguing is very upsetting to them. Triggers can also be internal. Upsetting thoughts and negative self-talk can trigger overwhelming emotions just as readily as external events. Jasmine reports that she feels very sad and hopeless when she thinks about how badly she is doing in school.

The most basic way to help play therapy clients discover the connection between their emotional reactions and the trigger events that cause those reactions is to look for and point out those situations, thoughts, and self-statements that seem to produce strong emotions in your clients. Remember earlier we discovered that Hector has difficulty with frustrating situations, Jessica has trouble with situations that seem to remind her of the domestic violence she witnessed when she was very young, and Jasmine reacts with anxiety when thinking about her performance in school and her chess-playing skills.

Let's take a look at how Jasmine's therapist helps her discover her emotional triggers. Jasmine's therapist noticed that Jasmine responds with intense anxiety to any situation in which she thinks she isn't performing perfectly, and often becomes tearful and angry with herself if she feels that she's missed a chess move or doesn't play as well as she could have. Rather than deciding not to play chess anymore, Jasmine's therapist encouraged her to continue to play during sessions, helped her make the connection between her emotional reactions and the negative things she was saying to herself, and began to introduce coping strategies that Jasmine could use to manage her emotions during the game.

BUILDING COPING SKILLS

Once clients have been able to identify their emotions by connecting them with their physical manifestations, and possibly to the internal and external events that elicit them, they are ready to learn strategies for managing those emotions. In this chapter we'll focus on using play to teach clients how to use deep breathing, relaxation, thought stopping, and coping self-statements.

The therapist should always remember to model the use of all coping strategies during play. The therapist will have many opportunities to demonstrate the coping skills they are hoping to help their clients acquire. For example, while playing a frustrating game, the therapist can take a deep breath before attempting her move, can relax her shoulders while having difficulty with the game, and can say things such as, ''This is hard. I'm not sure that I can do it. That's okay, though. People don't have to be good at every game they play.''

Breathing Strategies

Deep breathing (also know as abdominal breathing or diaphragmatic breathing) can be very effective for managing strong emotional reactions, especially those that involve a physiological stress response. Deep breathing engages the parasympathetic nervous system to reverse the ''fight or flight'' reaction people commonly have when under stress. Deep breathing, however, can be difficult for children to learn and use. Here are some play strategies for teaching children to regulate their emotions through deep breathing.

Strategy 1: Blowing Big Bubbles. Bubble blowing can be very useful for teaching children how to take deep, relaxing breaths and slow down their breathing. More specifically, asking children to slowly blow very large bubbles will automatically help them produce deep and relaxing breaths. If the child blows too hard and forcefully, the bubble will quickly pop. If she blows too shallowly, she won't produce a bubble or it will leave the bubble wand before it becomes very big.

The therapist can ask her client to see what happens when they use different kinds of breaths to blow bubbles. The therapist can model the different breaths first or can blow the bubbles along with the child. First, the therapist and the child should take a big breath in and blow very hard and fast. In most cases, no bubbles will be produced because the breath was too strong and the bubble will pop immediately, or lots of very small bubbles will be produced. Next, the therapist and the child can use small shallow breaths. No bubbles or very small bubbles are likely to be produced. Finally, the therapist and the child can take deep breaths in and blow in a gentle but sustained way. The child will find that this kind of breathing is the only kind that will produce a large bubble. In almost all cases, children report feeling calmer and more relaxed after blowing bubbles. The therapist should check with the child to make them aware of how the activity affects their bodies.

Once the child has mastered blowing bubbles, the therapist should ask the child to pretend that she's blowing a bubble using the exact same technique. It may be both helpful and additionally relaxing for the child to imagine watching a bubble getting bigger as she pretends. The therapist can now talk about how the child can use imaginary bubble blowing to calm herself down when she is feeling distressed. It's important that the child practice this technique at home so that she will have the necessary skills to employ it during times of stress and emotional upset. If possible, include parents in real and pretend bubble blowing so they can see how calming the activity is and use it at home with their children.

While it might appear that bubble blowing is appropriate for use only with younger children, it has been my experience that older children and even adolescents enjoy the activity. Unlike younger children, adolescents are able to learn deep-breathing techniques without blowing bubbles. Instead, the activity is useful for them because they find it to be relaxing and calming.

Hector and his siblings all enjoyed blowing bubbles in their sessions with their therapist. Mr. and Mrs. Vega made sure that bubbles were always available for the children, and they also learned to help the children use deep breathing when they became distressed at home.

Strategy 2: Physically Arousing Games. Games that naturally increase the child's heart rate can be used to teach children to slow and deepen their rate of breathing. The therapist used this strategy especially when working with Hector, who loved being active and had great difficulty sitting still in her office. The therapist would take Hector outside for a game of handball and would periodically stop the play and prompt Hector to pay attention to how fast he was breathing and how hard his heart was beating. The therapist would explain that the deep breathing Hector learned while blowing bubbles can calm his body down and make his breathing and heartbeat slower. After demonstrating and practicing, the therapist explained that Hector could use deep breathing to calm down when he's having difficulty managing strong emotions.

After the game was over, the therapist engaged Hector in a discussion of times in his life that using deep breathing would have been helpful. The therapist next had Hector think about the coming week and predict any situations that might elicit strong emotions, and asked him to practice deep breathing in that or any other distressing situations that might arise during the week.

This same technique would be very effective for six-year-old Jennifer, although she probably would not be able to engage in deep breathing without prompting from an adult or anticipate future stressful situations. Children under about age nine need adults to remind them to use coping strategies when they need them.

RELAXATION

Relaxation strategies help children reduce tension in their bodies and distract them from any physical and cognitive distress they may be experiencing when they are feeling overwhelmed by their emotions. Most muscle relaxation techniques for adults involve having clients tense and relax different muscle groups. Many children, especially young children, have difficulty with these techniques. Children tend to have an easier time when the therapist pairs muscle relaxation with imagery (Koeppen, 1974).

Richter (1984) found that children had more success using relaxation techniques if they were able to practice and use the techniques over an extended period of time. It's important, therefore, that the child practice relaxation techniques outside of the play therapy sessions, and if possible, that parents learn and coach their children on these techniques when they're at home.

Strategy 1: Pretend Play. As stated above, children tend to have an easier time when the therapist pairs muscle relaxation with imagery. In addition, Heffner, Greco, and Eifert (2003) conducted a study to examine children's responses to how relaxation exercises were explained and practiced. They found that every child in their study preferred exercises in which they had to pretend while relaxing (e.g., pretend you are a turtle going into its shell) over those in which they were given only instructions (e.g., squeeze your shoulders up to your ears).

Koeppen (1974) recommends that children imagine scenarios that will produce muscle tension and then relaxation and then act out the scenario. Using Koeppen's technique, Hector's therapist has him imagine that he is making lemonade by squeezing lemons (clenching and unclenching fists), stretching like a cat (tensing and relaxing arms and shoulders), pulling his head into his shell like a turtle (shoulders and neck), biting a large jawbreaker (jaw), twitching his nose to get a fly off of it (face and nose), squeezing through a fence (stomach muscles), and squishing his toes in a mud puddle (legs and feet).

Strategy 2: Identifying Calming Activities. During the course of active play, game play, or pretend play, the therapist can help the child identify activities that make him or her feel calm and relaxed. Hector's therapist helped Hector see that physical activities such as basketball and handball distract him from overwhelming feelings. Hector and his therapist also discovered that playing cards calms Hector down and makes him feel safe. Hector told his therapist that he often plays card games like *Crazy Eights* and *War* with his foster father.

Once the child and the therapist identify calming activities, the therapist can help the child find ways to engage in those activities when they are feeling distressed. Hector and his therapist talked about and wrote up the following plan for Hector:

When I get upset I can:

1. Breathe
2. Relax
3. Tell my mother or father I'm feeling upset
4. Ask my father to play cards with me
5. Ask to go outside and ride my bike
6. Ask to go play basketball

Strategy 3: The 5X5 Senses Game. The 5 × 5 Senses game helps children identify the kinds of situations and stimulation that relax them. To play this game, present the child with five smells, five sounds, five tastes, five textures, and five things to look at. The therapist should choose objects that would be appealing to the child and could be brought into the session. Ask the child to interact with the different objects and pay attention to how they make the child feel. Next, the therapist can ask the child to pick the one or two objects from each column that make them feel the calmest, safest, or happiest. An example for Hector might be:

Smell	Taste	Touch	Hearing	Vision
Cinnamon	Chocolate	Furry stuffed animal	Song	Picture of sister
Vanilla extract	Skittles	Golf ball	Sea shell	Picture of foster family
Lavender soap	Gum	Keychain with keys	Imagining foster father's voice	Blue sky

Smell	Taste	Touch	Hearing	Vision
Foster father's cologne Piece of leather	Sunflower seeds Toothpaste	Smooth stone Rubber band	Classical music Nature sounds CD	Picture of water Favorite action figure

Hector decided that the smell of his foster father's cologne was very calming for him, and that he also felt calmer when chewing gum, feeling a smooth stone, listening to rap music, and looking at a picture of his sister. Hector's therapist met with him and Mr. and Mrs. Vega, and they came up with ways for Hector to have easy access to the things that calm him down. Mr. Vega soaked a handkerchief in his cologne and gave it to Hector to carry in his jeans pocket. Mrs. Vega bought Hector a large pack of chewing gum and checked with him periodically to make sure he had enough for the coming week. (Mr. and Mrs. Vega talked with Hector about not chewing gum in school.) Hector and Mr. Vega went out to look for a smooth stone for Hector to carry around in his pocket, and they also gave him a picture of his sister Jasmine that he could add to the smooth stone and handkerchief. Finally, Hector made sure that he had his CD player with him in his book bag so that he could listen to his favorite music when he needed to.

THOUGHT STOPPING

Thought stopping is a valuable tool for helping children cope with thoughts that are distressing. The technique also helps children see that they have control over their thoughts and can redirect them when they need to focus on other things, such as schoolwork or playing with friends. Jasmine's therapist taught her this technique because Jasmine often becomes depressed and feels hopeless when she thinks about mistakes she makes in school. Thought stopping is almost always paired with positive imagery or positive self-talk so that the child learns to stop upsetting thoughts and replace them with coping or calming images or self-statements. March and Mulle (1998) recommend that children can also replace distressing thoughts by singing or rapping.

As with all of the other techniques we've discussed so far, thought stopping is most effective when it is practiced repeatedly and when parents help the child apply the technique to situations outside of therapy.

Strategy 1: Identifying Upsetting Thoughts. Before children can use thought stopping, they must be aware that their thoughts can cause them to become upset, angry, sad, and so on. During play the therapist can point out self-statements naturally arising from play that could lead the client or other children to feel upset, angry, sad, and so on. Jasmine's therapist noticed that while playing chess, Jasmine would often call herself stupid, an idiot, and a moron. When asked to talk more about these statements, Jasmine said that she has thoughts about how stupid she is at least five or six times each day. When her therapist asked her about how these thoughts make her feel, Jasmine said that they make her feel depressed and hopeless, and like not working on her schoolwork or seeing her friends. Jasmine's therapist helped her see the connection between her thoughts, her feelings, and her behavior.

Strategy 2: The Freeze Upsetting Thoughts Game. The Freeze Upsetting Thoughts Game is appropriate for use with elementary school children. Once the therapist has helped the child identify one or two upsetting thoughts, the child walks or runs around while verbalizing the upsetting thoughts. When the therapist yells ''Freeze'' the child stops moving and is instructed first to stop all movement and then to replace the thought with a positive self-statement.

Six-year-old Jessica plays this game with her therapist. They had previously discovered that Jessica sometimes tells herself that she is a bad girl, and that this thought often leads to her incidents of hyperarousal and overactivity. When they played the Freeze Upsetting Thoughts Game, Jessica ran around the room saying, ''I'm a bad girl,'' and then she froze that thought and replaced it with, ''I'm a nice girl,'' when her therapist yelled ''freeze.'' Jessica loved this game because it was active and fun, and she also clearly learned that she has control over thoughts that can upset her and disrupt her behavior.

Jessica's therapist taught Mr. and Mrs. Vega to help Jessica yell ''freeze'' to her upsetting thoughts when she expressed them at home. Jessica won't be able to use thought stopping without help from adults for several years.

Strategy 3: The Thought-Stopping Remote Control. Another technique for teaching thought stopping is to have children point a real or imaginary remote control at their upsetting thoughts. The therapist explains that the child should (a) push the pause button when he or she has an upsetting thought, (b) think about a positive self-statement, (c) push the play button, and (d) say the positive self-statement aloud. Alternatively, the therapist can say the upsetting statements aloud, and the child can point the real or imaginary remote control at the therapist to ''Stop'' or ''Pause'' the therapist.

Two of Hector's favorite activities are watching TV and playing video games. The idea of using a remote control to gain control over upsetting thoughts was highly appealing to Hector. His therapist initially chose to bring in a real remote control for him to point. Eventually, though, the therapist transitioned Hector to using an imaginary remote control so that he could use the technique in school without anyone knowing.

Coping Self-Statements

As we discussed above, one way for children to cope with overwhelming feelings is to say calming or comforting things to themselves. Self-talk can guide children though difficult situations, help with problem solving, and serve as a means for staying calm. Unfortunately, many children with affect dysregulation don't know how to stop to talk to themselves before reacting in a distressing situation (Kimball, Nelson, & Politano, 1993). Other dysregulated children say distressing things to themselves, such as ''I can't take this anymore,'' ''I'm going to freak out,'' ''I'll never be able to do the right thing,'' or ''I can't handle this.''

During play, the therapist can model and help the child practice using coping statements. The therapist should choose games and play activities that resemble real-life situations that cause the child difficulty. When working with Jasmine, the therapist concentrates on activities that elicit performance anxiety, such as playing chess. The therapist focuses on playing frustrating games with Hector because Hector's foster parents and teachers report that he becomes aggressive when he is frustrated. When the therapist plays with Jessica, she makes the dollhouse and doll family available because this play sometimes leads Jessica to become distressed and hyperaroused.

Strategy 1: Self-Talk in Pretend Play. As discussed above, the therapist can help the client learn and practice the use of coping self-statements by choosing pretend play materials and situations that elicit emotions that the client has difficulty managing. The therapist's tasks are to notice any unhelpful or distressing statements the child makes, model coping self-statements, and prompt the child to use coping self-statements.

When the therapist was ready to work on self-talk with six-year-old Jessica, she chose to make the dollhouse and doll family available. The therapist knew that Jessica frequently played aggressively with the dolls and often had the mother and father dolls say cruel and emotionally abusive things to the doll children. The therapist decided to join in the play as one of the children and modeled statements like, ''We're not bad kids; they must just be in a bad mood,'' or ''Let's all sit together and make each other feel better until they stop yelling.'' Finally, the therapist asked Jessica what her doll could say to make herself feel better in this situation, and praised her for her efforts.

Strategy 2: Frustrating Games. Many affectively dysregulated children have difficulty tolerating frustration. By playing frustrating games such as *Operation*, *Sorry*, or *Uno* (or *Chutes and Ladders* with young children), the therapist can model five things:

1. Talking yourself through a difficult task: ''If I just take my time, I'll be able to do it.''
2. The use of humor: ''I'm really bad at this. It's a good thing I don't get paid for playing this game.''
3. The expression of hope in the face of disappointment: ''That's okay, I'll do better on my next turn.''
4. The preservation of self-esteem in a difficult situation: ''I may be bad at this game, but I'm really good at basketball.''
5. The need to take a time out from a difficult situation: ''I'm too upset to play anymore. Let's do something else.''

Often the child will begin to incorporate the modeled statements into his playing of the game, and this should be pointed out and reinforced with praise. A conversation can follow where the therapist discusses with the child how using coping statements helps the child deal with the game-related frustration.

Some children will not automatically pick up on the modeling and incorporate coping statements into game playing. In this case, the therapist can directly discuss coping statements and how they can be helpful. The therapist can then direct the child to use the modeled statements when they begin to become frustrated as they continue to play the game.

Hector and his therapist often play *Operation*, a battery-operated game consisting of a patient with a large, red light-bulb for a nose who is lying on an operating table. Hector and his therapist take turns removing plastic game pieces representing ailments such as water on the knee, a broken heart, a funny bone, or a charley horse from holes in the board using a pair of metal tweezers. If the tweezers touch the metal edge of the opening, a buzzer sounds, the patient's nose lights up, and the player loses their turn.

Removing the pieces is difficult, so Hector and his therapist almost always make the physiologically arousing buzzer go off while they play. Before they started working on coping self-statements, Hector always became too frustrated to continue the game, and once he even threw it against the wall. Hector's therapist began modeling coping statements, such a, ''If I just take my time, I'll eventually be able to get this piece out,'' or ''This is so frustrating. I'm going to keep trying anyway,'' when it was her turn. She also began saying them to Hector when it was his turn. She might say, ''I know you can do it if you keep trying'' or ''It's okay if you can't do it today.'' Finally, she began prompting Hector to use his own self-statements as they played.

A FINAL NOTE FOR THERAPISTS

Hopefully, the examples given throughout this chapter will provide therapists will many ideas for using play to help children regulate distressing emotions. As long as therapists keep their clients' treatment goals in mind, they can be creative in the exact methods they choose for helping the child achieve those goals. If one strategy doesn't work, try others presented in this chapter or of your own devising.

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CHAPTER 18

Building Self-Esteem, Coping Skills, and Changing Cognitive Distortions

DIANE FREY

IT WAS JOHN Milton who said, ''The mind can make a heaven of hell or a hell of heaven.'' This concept truly represents some of the underlying premises of cognitive behavioral therapy. Translating that thought to children in cognitive behavioral play therapy (CBPT) has represented a challenge to mental health practitioners. This challenge is not unique to CBPT. It has taken the profession several decades to discern that it is not that children cannot comprehend some of the concepts of therapy; it is more that the professionals have had to be creative in knowing how to translate and transmit the concepts.

BENEFITS OF PLAY THERAPY AND CBPT

Play therapy is an effective modality for interacting with clients of all ages with various theoretical treatment approaches. Play therapy assists individuals in expressive and receptive language. Play is the language of the child but also sometimes the language of adolescents and adults.

Much of what is written about CBPT focuses on preschool children. It addresses the developmental level of these children and the matching of play therapy techniques to developmental level. While adults function at a different cognitive-developmental level than children, they are often emotionally at a different developmental level than their cognitive developmental level. This asynchrony of development for individuals makes play therapy effective for clients of all ages.

In addition, CBPT is effective for clients of all ages who are resistant. Preschoolers may be resistant to traditional talk therapy because they have been abused. Likewise, adolescents and adults might also be resistant to traditional therapy for the same reason. Clients older than preschoolers could also be resistant because they were referred by the court against their will, they have been instructed not to tell anyone certain information, and/or they have a belief system which denigrates the effectiveness of therapy. (These are just a few of the representations of reasons for resistance.) As such, therefore, CBPT can be very beneficial to the clients of all ages.

Clients of all ages often present with denial. Adolescents often state that the problem is with their parents, not them; therefore their parents should be in therapy. Individuals with addictions often deny this psychodynamic. Adults in the workplace often deny responsibility for their behavior and/or blame others for workplace problems. All these issues of denial can be addressed using CBPT.

Clinicians often encounter clients who are psychologically unaware of what is causing them distress. While this is particularly true of preschoolers and young children, it is often also true for adolescents and adults. A fifth grader might be unaware that child physical abuse in his home is an inappropriate method of parenting and consider such parenting to be the norm, therefore not mentioning it in therapy. A teenage girl might not realize that earlier sexual abuse is related to poor academic performance and/or lack of interest in dating or promiscuous behavior. A depressed adult might not realize that her depression stems from anniversary syndrome issues of the death of her child. If such clients do not realize these connections, they cannot verbalize them in traditional therapy. Through CBPT and the use of drawings, clay, or bibliotherapy, these issues often surface thus aiding the therapist and client in exploring new avenues for therapy.

The effectiveness of CBPT is often referenced in regard to clients who are verbally deficient due to various circumstances. An adult client could be developmentally delayed. A school-age client could be selectively mute. An adolescent could be ego arrested at an earlier age due to some trauma. Clients older than preschoolers could suffer from PTSD and be verbally deficient when it comes to discussing the trauma. All such clients can benefit from CBPT.

Indeed some older clients can discuss some concerns quite well using traditional talk therapy but sometimes meet an impasse. It is then that CBPT could also be helpful. Perhaps the client can discuss dissatisfaction with peer relationships, but not discuss issues pertaining to sex. CBPT would help such clients.

CBPT also provides the opportunity for spontaneity that traditional talk therapy does not. Often therapists are so focused on treatment goals that they lose a grasp of other concerns that the client might have that were not previously stated in a treatment plan. A client of this author who is a federal judge came to therapy to discuss a vexing legal problem presented to him. It was only while tangentially creating an object in the sandtray that he began to reveal the self-loathing he had for himself. This self-esteem issue later became a major focus of therapy although not initially presented as a goal by the client.

Based on these client conditions, therefore, this chapter will not only focus on the use of CBPT with preschoolers but also with clients of all ages—2 to 90-plus. CBPT techniques will be presented to deal with such concerns as anger, anxiety, perfectionism, acting out, divorce, social skills, abuse, and self-esteem. Case studies will further illustrate the applications of CBPT for clients of all ages.

Another advantage of using CBPT with clients is related to the literature on human learning. Most people prefer to discuss . . .

1. Others	rather than	themselves
2. The past	rather than	the present
3. Thoughts	rather than	feelings
4. Positive feelings	rather than	negative feelings

(Durant, Frey, & Newburg, 1991).

Most therapy takes place while discussing the self in the here and now and is focused on problematic feelings. Clients seldom arrive in therapy ready to relate at that level. An informed therapist will assess where clients fall on each of these continua and then meet the client at that level. For CBPT it is much like the process of shaping. The CBPT therapist meets clients at the level of readiness and then moves toward the next position on the continua hoping the client will shadow the therapist, gradually working their way across each continuum until they are discussing the concern using words. CBPT helps clients to feel less threatened in therapy, because they can begin at their comfort level—perhaps relating concerns symbolically through play therapy—and then evolve into more direct interaction. This process will be evident in the case studies illustrated later in this chapter.

SELF-ESTEEM AND CBPT

Concerns about low self-esteem are very evident in issues presented by parents, children, and adults in mental health settings. Although self-esteem issues are not recognized as a disorder or syndrome, low self-image, high self-criticism, and distorted self-evaluation are evident in the diagnostic or associated features of many disorders. Low self-esteem is identified in depressive disorders and is associated with attention-deficit/hyperactivity disorder, oppositional defiant disorder, phobias, and eating disorders. Low self-esteem is also found in children with learning disabilities and is evident in abused children. There is evidence that self-esteem is a predictor of behavior and is also a mediator and/or indicator for various clinical conditions (Shirk, Burwell, & Harter, 2003). Self-esteem is central to the etiology and maintenance of various psychopathologies (Shirk, Burwell, & Harter, 2003). There is research evidence that self-esteem can be changed through therapy and that these changes are associated with positive changes in other areas of functioning.

COGNITIVE BEHAVIORAL PLAY THERAPY TECHNIQUES TO MODIFY LOW SELF-ESTEEM

A review of the literature of cognitive behavioral treatments suggests that cognitive techniques that target specific self-evaluative processes show positive results for improving self-esteem (Shirk, Burwell, & Harter, 2003).

TREATMENT PLANNING FOR CBPT FOR LOW SELF-ESTEEM

Using the case formulation approach of cognitive behavioral therapy planning involves answering a series of four questions:

1. What are the manifest problems?
2. What pathogenic mechanisms are associated with the problem?
3. Are one or more pathogenic mechanisms evident in the specific case?
4. What treatment procedures have been successful in altering the pathogenic process?

Common pathogenic mechanisms linked with low self-esteem are unrealistic self-standards, inaccurate self-evaluations, undifferentiated self-structure, and inauthentic or false self. Although low self-esteem is not solely the result of maladaptive cognitive processes, many cognitive interactions can be helpful to clients. It should be noted that self-esteem is also a function of one's environment. Since one's environment is processed through cognitive filters, however, cognitive process can enhance or lessen environmental impact.

CBPT Techniques for Unrealistic Self-Standards

This pathogenic mechanism is best known to clinicians as perfectionism. In CBPT there are many techniques to challenge unrealistic expectations. One such CBPT technique involves the therapist acquiring some clay, pennies, marbles, and/or chips. The therapist asks the child to write in the clay, ''No one is perfect.'' The therapist discusses with the child that each time she accepts a mistake and tries again she will get a penny, chip, or marble in a play trophy cup. When the cup is full, the child can keep the cup and be given a reward of choice from a toy grab bag or from the child's parents. The therapist can process with the child how mistakes can lead to great things. The book, *Mistakes that Worked* (Jones, 1991), can be used by the therapist to help the child reframe the concept of mistakes from negative to positive. The book reviews many everyday products that began as mistakes and are now popular. (The cleaner ''409,'' is named such, for example, because it took 409 trials to finally make a good product.) A real trophy cup could be obtained using the same procedure and then engraving it with the child's name when it is full.

Another helpful CBPT technique involves asking the child to draw a picture of the 10 happiest events in his entire life. After the child has drawn the 10 events, ask him to tell if each event was perfect or not. For example, the family went to Disneyland or Disney World. Ask the child if that event was perfect—true or false. Almost always there is some element of imperfection in every event—the flight was late or cancelled, some family member was sick, someone forgot a camera. After assessing each event as perfect or not perfect, the clinician dispels with the child the myth that ''perfectionism equals happiness.'' The child's own drawings of happy times and their imperfections serve as a vehicle for the therapist to reframe this concept and negate the paired associate.

A technique called ''Brush it off'' (Frey & Fitzharris, 1998a) can also be used to help children let go of painful events which could have led to their feeling less than perfect, with low self-esteem. The clinician needs a scrub brush, a nickel, a variety of puppets, or dress-up clothes. The therapist asks the client to try to brush off the nickel from the palm of the therapist's hand. (The client must use ordinary brushing methods, only the bristle end, not the handle.) When the client discovers it is impossible to brush off the nickel, initiate a discussion about how difficult it is to brush off others' rude remarks, rejections, negative statements. Explore painful situations that may still linger and how the client has not been able to brush them off. Ask the child to select a puppet(s) to represent himself/herself and the antagonist. Reenact a past painful situation in which the therapist plays the role of the client, the child plays the role of the antagonist as mean, disrespectful, and so on. The therapist portrays the child puppet as assertive, using positive ''I-statements'' such as ''I don't like what you are saying'' and ''that hurt my feelings, leave me alone.'' After the interaction, process with the child how she felt. Discuss with the client how her thoughts can be used to change feelings. Emphasize that changing one's thoughts are a method to brush off the antagonist's remarks and behavior. Affirm that this change is possible by having the client be himself/herself with the appropriate puppet and the therapist portraying the antagonist puppet. Process how empowering this was for the client and encourage her to use new words and thoughts to brush it off.

''Put a lid on it'' (Frey & Fitzharris, 1998b) is a technique used to help clients dispute their inner critic. (Inner critics can be a source of perfectionism.) Decorate a small can with a lid and put the phrase ''Put a lid on it'' on the front of the can. Ask clients to write phrases or words their inner critic tells them, such as ''I'm such a loser,'' ''I'm no good,'' ''I can't do it.'' Place these written responses in an envelope and attach the envelope to the back of the container. Ask clients to select messages from the can and role-play the message. To confront the inner critic, ask the client to place the written response in the container, put the lid on the container, and state, ''Put a lid on it.'' Each time a written statement is read and role-played, ask the client to put the written statement in the container, put the lid on the container, and state, ''Put a lid on it.'' Whenever an inner critic invades one's thoughts, inform clients they can stop the negative thoughts by inwardly saying, ''Put a lid on it.'' End the session by having the client say a positive self-statement (i.e., ''I can do it,'' ''I'm okay!'' etc.).

CBPT TECHNIQUES FOR UNREALISTIC SELF-EVALUATION

''I've Been Framed'' (Frey & Fitzharris, 1998c) is a CBPT technique to help clients obtain a realistic self-image. In group CBPT, ask clients to make positive picture frames using colored craft sticks. Decorate these with pompoms, glitter, stickers, toy objects, and so on. Ask participants to work in dyads. Ask each pair to draw ''head shots'' of each other with markers. Cut the pictures to fit the stick frames. Glue the ''head shots'' to the backs of the frames. Give the picture to the rightful owner. Discuss how individuals saw each other. Discuss how one feels about the drawing—accuracies, inaccuracies, and so on. Discuss what can and cannot be changed about self. A variation of the technique would be to have clients in individual CBPT draw their own portrait and then discuss thoughts and feelings about it.

Another technique for group CBPT involves folding a piece of paper in half lengthwise. Ask clients to put their name at the top of each side. Ask the clients to list their good qualities and the things they like about themselves on the left side of the page. The next step of this game is to pass the paper to the client's right and ask that person to list good qualities she or he sees in the person named at the top of the page. The paper is then passed again around the group until everyone has had a chance to list the qualities they experience in the person. When the paper returns to the owner, the client is asked to compare the two sides. To process this game ask clients to compare how others see them compared to how they see themselves. How might they let others see more positive qualities of themselves?

CBPT Techniques for Undifferentiated Self-Structure

A group CBPT technique called ''I like my neighbor who . . .'' (Frey & Fitzharris, 1998d) is appropriate for all age ranges. In this technique the therapist gathers together enough chairs in a circle for all but one member of the group. The person without a chair, usually the therapist in the first round, states a particular characteristic like, ''I like my neighbor who has brown eyes.'' Everyone who has brown eyes must then race to a different chair while the therapist also takes a chair. The person without a chair states another characteristic like, ''I like my neighbor who wears glasses.'' Everyone wearing glasses must move to a different chair. With adults the characteristics are often, ''I like my neighbor who likes poetry/gourmet food/yoga,'' and so on. The procedure continues until the therapist determines that enough characteristics have been reviewed. This play therapy technique helps participants to understand the various aspects of themselves. Processing can also center around how people in the group are the same and how they are different.

Another group CBPT technique is called, ''It's in the bag'' (Frey & Fitzharris, 1998e). The clinician will need several bags, various toys, sandtray objects, Legos, other creative play supplies (paint, clay, etc.). Each person is asked to put objects in a bag representing himself. Ask clients to imagine they were not going to be living in the vicinity anymore; therefore, this bag would serve as a reminder of who they are. After everyone shares their bag in the group, the therapist asks individuals to draw the name of another participant from a hat, then bring that person in a bag to the next session. This process helps clients to understand their variegated selves as well as how others view them.

An individual or group CBPT technique for helping clients to avoid an undifferentiated self is called, ''Can we talk?'' (Frey & Fitzharris, 1998a2). In this technique both the therapist and client(s) choose a puppet, doll, or stuffed animal to represent themselves. The client is informed that this is a play talk show in which the therapist will be the host and the client will be the guest. Set up a stage for the ''talk show'' and make a microphone using a paper towel tube cut in half with a small plastic golf ball in the open end. Cover with foil. Ask clients to choose a puppet, doll, or stuffed animal that represents them. When the show is ready to begin it could be videotaped or taped with a camcorder. The therapist/host introduces the guest by using his puppet to interview the client's puppet. While looking at the doll, animal, or puppet, the therapist asks nonthreatening questions such as the guest puppet's (doll, animal) interests, family, lifestyle, dreams, hobbies, and so on. After the interview, thank the guest and conclude as if it were a real talk show. Process the technique by playing back the tape (if recorded) and/or discussing what motivated the client to choose a particular doll, puppet, or animal to represent him/her. Conclude by discussing what the client learned about him/herself.

In ''The Name Game,'' (Frey & Fitzharris, 1998f) clients use magnets and a magnetic board to spell their first name. Using the letters of their name as the first letter of an adjective, clients spell out key words which describe themselves. For example, Terri might be ''T'' terrific, ''E'' eager, ''R'' restless, ''R'' rebellious, ''I'' imaginative. Discuss when and where in life clients exhibit these characteristics. Facilitate discussion about various aspects of self that everyone has. The therapist would also ask clients to spell out names of family members on the magnet board using the same process, then discuss how clients are the same and/or different in personality to their parents, siblings, and so on.

A variation of a scavenger hunt can be used to explore various aspects of self. In this technique clients are asked to go on a self-esteem scavenger hunt. Ask clients to go on an inner search of self and list and/or draw as many positive and negative characteristics of themselves. Discuss how often peoples' negative characteristics outnumber the positive. How could the list of positives be increased? How can the negative characteristics be dealt with in an effective manner?

A self-esteem banner can be created to help clients become aware of various aspects of self. Discuss how banners have been used for centuries to symbolize and announce who a person is (for example, a lion in a banner meant strength, a fleur-de-lis symbolized the royal family of France). Create a banner with nine different areas. Ask clients to draw in the first area a picture of how you would like to be: Ideal self. In the second space draw a picture of what symbolizes the real self. In space three, draw a representation of the client's fantasy self. In area four draw a picture of self for others—the me everybody knows. Draw a picture of the hidden self—the me hardly anyone knows—in area five. In area six symbolize things you do well— present self. In area seven draw a representation of your future self—10 years from now, for example. The self in process can be drawn in area eight—that is, things you would like to do well. In area nine symbolize one thing you would like to have said about you if you died today.

The banner area could be lessened and simplified for younger children. Content area could also be modified.

If doing this in group CBPT, the therapist could post the banners anonymously and ask group members to match the banners to individuals. (This provides clients with feedback from others thus helping them acquire an accurate self-image, discussed earlier in the chapter.) Clients could wear their banners and circulate around the room reading each others' banners. Process what aspects of self were easiest to represent and what were hardest? What representations caused clients to wonder about themselves? If in group CBPT, discuss what aspects shared with others were reinforced or confirmed for you?

To assist with developing a differentiated self, therapists could also do a newspaper identity technique. In this technique, the therapist gathers several old newspapers, tape, glue, and sheets of newsprint. Clients are asked to compose a brief autobiographical sketch of self using words, phrases, or sentences from the newspaper. These are then cut out and glued to newsprint. Clients then discuss what they selected. In group CBPT, clients can be asked to cut words, sentences, or phrases for each other. Discuss how such words help the client gain new insight. In what ways were the words contributed alike or different? What would that tell each client?

CBPT TECHNIQUES FOR THE INAUTHENTIC SELF

''Relationship Mask'' (Frey & Fitzharris, 1998g) is an effective technique to help clients identify different masks people wear. Gather some paper plates, markers, feathers, gems, glitter, tacky glue, scissors, and craft sticks or acquire some papier-mâché masks available at most craft and art supply stores. Make masks from the paper plates or the papier-mâché forms. Embellish them with feathers, gems, sequins, glitter, and so on. Make eye holes. Ask clients in individual or group therapy to model and discuss their masks. Facilitate further discussion about how people wear masks in different settings with different people—family members, friends, peers, others. Ask if clients pretend to be someone they are not with others or put on a mask to get through a situation (i.e., rejection, failure, grief, etc.). Process how people wear masks in everyday life to camouflage their feelings. End the discussion by focusing on how clients can be true to themselves without wearing a mask.

This CBPT technique can be used with clients of all ages. The therapist places a candy dish or dish of fruit in the middle of the group. All group members except one are given instructions on a piece of paper to ''eat the candy/fruit slowly and behave as if it is *very good* candy.'' Try to get everyone to eat some candy or fruit. Give one member of the group instructions on a piece of paper that says, ''Do not eat or take candy under any circumstances.'' Tell everyone to keep their instructions a secret. Ask everyone to follow the directions for five minutes. Discuss how it felt to be the person who resisted. How did everyone feel about the person who resisted? How does it feel to be the only one in a group exhibiting certain behavior? Have clients ever felt peer pressure to do something? What could they do about it? How can an individual remain true to self? (This technique is especially helpful for adolescent clients.)

Another helpful CBPT technique relevant for the inauthentic self is the use of a dollhouse, dollhouse furniture, and dollhouse people. The therapist can ask the client to identify a special place in the house (i.e., bedroom, bath, garage/workshop, garden, rec room, etc.). Discuss what makes the place ''special.'' Talk about times when the client needs to retreat to the special place to find relaxation, quiet, an escape. Process how retreating to this place can help the client become more restored and in touch with one's true self. This special place can aid in challenging cognitive distortions, lowering stress, and strengthening positive self-statements.

A variation of this technique can involve playing the song, *In My Own Little Corner,* from the soundtrack of *Cinderella* (Rogers & Hammerstein, 1968). Ask clients to close their eyes and think of their own little corner. What positive self-statements can they say to help themselves? When the song is over ask clients to draw their own little corner of the world.

BIBLIOTHERAPY

Bibliotherapy is a frequently used CBPT technique. In CBPT, bibliotherapy is often paired with drawings, puppetry, clay, sandtray, and/or dress-up clothes. One such bibliotherapy technique relevant to the topic of inauthentic self is the book, *The Empty Pot* (Demi, 1996). This story is about an emperor who sets as a criterion for his successor the child in the kingdom who can grow the best flowers, since everyone in the kingdom enjoys flowers. Unbeknownst to everyone, the king cooked all the seeds before giving them to the children. The main character, Ping, is very troubled because he cannot grow flowers, while the other children can. On the decisive day, Ping is the only child who comes before the king with an empty pot. The king chooses Ping as his successor because he was the only child who was authentic. (The other children used other seeds when theirs would not grow.)

After the therapist shares with the client most of the book, she can stop before the unexpected ending and ask the client to act out the ending he predicts, using several finger puppets or puppets depicting the various roles in the book. Discussion can then compare how the author ended the book and how the client ended it. Processing can then occur about the value of the authentic self.

Additional bibliotherapy CBPT techniques for embracing self-esteem, but not necessarily limited to the common pathogenic mechanism previously discussed, could include asking the client to write a book. This author had been using CBPT with a nine-year-old client of low self-esteem. Bibliotherapy with subsequent drawing was among the techniques used. Spontaneously toward the end of therapy, he brought to the session a book he had made using cardboard covered with plain white pieces of paper that he glued to the cardboard. He had written and illustrated a book, entitled ''All About Joe.'' The following is the exact text:

> All About Joe
>
> Joe always wanted to play baseball. One day he saw a sign-up poster. He said to his dad, ''May I sign up?'' ''Yes son,'' said his father. Joe really liked playing baseball.
>
> One day the score was tied. Joe was up to bat. If he made a run the team would win the game. (At this point in the story the child drew a picture of ''Joe'' with a message bubble by his head with the thought, ''I think I can. I think I can.'') Joe repeated to himself, ''I think I can do it.'' Joe did it! They won!

(The child wrote on the spine of the book, ''All About Joe,'' the child's name as the author, and then the statement: ''Moral books—help children learn.'' On the back of the book he wrote: ''Moral: If you think you can, you can.'')

The child informed the therapist that he decided to make the book while waiting for his parents to pick him up to bring him to therapy. This book reflected the degree to which the child was internalizing the importance of self-statements and their relationship to self-esteem. A book to be authored by the client could also be done for a homework assignment in CBPT.

Other helpful bibliotherapy books on the dynamic of self-esteem is a series written by Virginia Waters. She authored a series of four books for children with accompanying pamphlets for parents. In *Freddie Flounder* (Waters, 1980b), the topic is self-acceptance. Freddie learns to accept himself as a fallible fish that does both good and bad things. He learns to challenge his cognitive distortions and inaccurate self-evaluations. In *Ludwig Learns to Light* (Waters, 1980d), Ludwig the Lightening Bug learns the value of positive self-statements. *Cornelia Cardinal Learns to Cope* (Waters, 1980a) is a children's story about the power of self-talk. In the book, *Fasha, Dasha, and Sasha Squirrel* (Waters, 1980c), each squirrel learns about the effect of thoughts on feelings.

Children can act out these stories with dress-up clothes, play them out in the sandtray, make a play with puppets representing these various animals, and/or draw out the story. Children have also created a video of the stories and then played them back and processed them with the therapist.

TECHNIQUES FOR SELF-ESTEEM BUILDING

Another CBPT technique that can be used to embrace self-esteem is called ''Fortune Cookies.'' In this technique the therapist prints on small pieces of paper, similar to ones used in fortune cookies, various self-esteem quotations. These can then be placed inside fortune cookies. Clients then choose a fortune cookie, read the fortune, and then discuss how that applies to their lives. Quotations are chosen which are age-appropriate. Some examples might be:

> Whether you think you can or think you can't, you're right.
>
> —*Henry Ford*
>
> I'm not perfect, but parts of me are excellent.
>
> —*Diane Frey*
>
> Know thyself.
>
> —*Greek quotation*
>
> Everything has its beauty, but not everyone sees it.
>
> —*Confucius*
>
> Most people are about as happy as they make up their minds to be.
>
> —*Mark Twain*
>
> Change your mind today and you build your world of tomorrow. Your mind is your garden.
>
> —*Kristen Zambucka*

Children could also draw a picture to correspond to a quotation.

USING MAGIC TRICKS

A magic trick which can be used in CBPT is called, ''Float to the Top'' (Frey, unpublished). Prior to the session the therapist mixes a few drops of food coloring with salt to make ''magic dust.'' Let this dry for approximately one half hour. When dry, place it in a decorative box or container. During the session, tell the client that you can make an egg float on water. Place the egg in a glass tumbler, and then fill the tumbler about half full of water. The egg will immediately sink to the bottom. Tell the client, ''You must not be thinking positive self-statements.'' Pull out the bag of magic dust (i.e., salt) and pour a lot of dust (salt) into the water. As the salt sinks to the bottom, the client witnesses the egg rising to the top. While pouring in the magic dust, state out loud some positive self-statements relative to the client's concerns. Process with clients how they can pick themselves up (like the egg) by making positive self-statements.

SELF-TALK AND ROLE MODELING

Self-talk is a key element to improving self-esteem. In *What to Say When You Talk to Yourself* (1986), Helmstetter discusses how children accept self-talk naturally. Children seem to be more willing to welcome positive statements about themselves. Children are closer to the original potential they were born with. ''Until we become programmed to believe what we cannot do, as children we are still willing to believe in what we can'' (Helmstetter, 1986, p. 147). Consequently, self-talk is a very important element in self-esteem interventions.

Another CBPT puppetry activity involves exploring the difference between high and low self-esteem. This technique is a modeling intervention. The therapist discusses indications of high and low self-esteem. Such indicators can be, for example:

High Self-Esteem	Low Self-Esteem
Secure	Insecure
Self-confident	Timid
Eager to learn	Unsure of Self
Gives others positive feedback	Puts others down
Cooperative	Brags
Unafraid of new experiences	Afraid of new experiences
Assertive	Aggressive
Can make friends easily	Difficulty making friends

Ask the clients to choose puppets and play out a skit demonstrating one of these indicators or a combination of indicators. The person not using a puppet guesses what is portrayed—much like in charades. Roles can then be switched. After several role-plays, a discussion can ensue around how puppets of low self-esteem can improve their images of self. Variations of this technique involve having clients select an indicator that most represents them and act this out with the puppets. In group CBPT, clients could portray each other using these indicators. Ask clients how accurate they think the portrayal is. Clients could also play out areas in their life where they feel high and/or low self-esteem. For instance, a child might excel at school with peers, but feel insecure in their own home. Process how the client could make home life as satisfying as school life.

Additional CBPT Techniques to Build Coping Skills and Change Cognitive Distortions

In addition to self-esteem issues, CBPT therapists frequently are faced with referrals involving anger management, bullies and victims of bullies, and emotional intelligence concerns. The following are CBPT techniques that can be used for these pervasive concerns.

Anger Management Techniques. The ''Ten Penny'' (Frey(b), unpublished) technique helps both therapist and client discuss self-statements a client is making. The client is asked to align 10 pennies on their sides, not leaning on anything, in a straight line. Allow the client 5 to 10 minutes to do this. It is a task that can be accomplished, although many clients believe it cannot be done. In the process of trying to accomplish the task, clients often verbalize their thoughts and demonstrate existing coping skills. This technique can be a helpful assessment technique in CBPT since it reveals the client's current coping skills for anger management. (Some clients give up very easily and do not even stand one penny on its side; others throw the pennies across the table or room, revealing a low frustration tolerance point, and then become vocal about how the task cannot be accomplished.)

To gain insight into clients' self-talk and problem-solving skills, a talk show game can be helpful (Kaduson & Schaefer, 2000). The therapist introduces the activity as a call-in talk show in which a caller states a problem and the child who is the expert answers. The therapist plays both the talk show host and caller. The caller states a problem the child is experiencing. The child can receive help from a puppet as well as the therapist. In between calls the client and the therapist discuss news items, and so on, but all calls should relate to the presenting concern of the child. It can be helpful to videotape the session to review later. The video can be shared with parents to enable them to learn about the child's coping skills.

To help children develop coping skills for anger and other concerns, therapists can use gel-based sticky hands (sold in novelty stores) to provide the client with a concrete object for a therapeutic metaphor. The sticky hand is introduced as a way to avoid being *grabbed* by someone else's words or actions. Explain that grabbing you into a conflict is a method others use to try to gain power over you. If the client allows himself to get pulled in, the other person is in charge.

Through discussions with the client, the therapist determines client triggers. The therapist then holds the long end of the sticky arm and throws the hand onto the client while making a grabbing statement, such as ''geek,'' ''retard,'' and so on. The client then makes a verbal response, which will de-escalate the situation and shake off the sticky hand. Continued practice helps clients to cope with difficult others.

Clients can be taught more reasonable self-statements about anger and other concerns by making fist puppets. The clients are asked to hold their hands in a fist, placing the thumbs into the fists up to the first joint. Draw angry eyes on one hand and calm eyes on the other. Ask the client to have the fist friends talk to one another. The angry fist friend could be still thinking about what was said to him, getting angry again, and/or wanting to hurt the other person for what was said. The calm, wiser ''fist friend'' tries to help the friend get over his anger, and think of coping self-statements and strategies. The therapist could also model adaptive self-statements using the fist friends.

Tic-tac-toe is another play therapy technique a therapist can use to help children learn positive coping skills. The therapist can develop a tic-tac-toe board with effective and ineffective coping strategies for anger management and other dynamics. The client is asked to put an X in a box that describes an ineffective strategy for anger management and O in any box that describes an effective strategy. An example of content for the boxes might be ''express your feelings in words,'' ''hit a pillow,'' or ''never speak again to the person with whom you are angry.''

To help clients of all ages to understand the value of dealing with anger in a progressive manner rather than allowing anger to augment into rage and explode, therapists can use balloons. Ask clients to blow up a balloon and tie off the end. Ask the client(s) in individual or group therapy to then break the balloon using any method. Then ask the client(s) to inflate another balloon but not tie it. Then tell the client(s) to slowly let the air out of the balloon. Process how clients felt in both situations. Usually clients report that they felt anxious, nervous, or tense when breaking the balloon. When allowing the air to escape gradually from the balloon, clients report feeling safe and feeling glad that no one got hurt and they were still able to let the air (anger) out of the balloon (self).

Relaxation Techniques. Relaxation techniques are an integral aspect of CBPT interventions. Such techniques are used in desensitization and also for other client concerns. The therapist gathers plastic water bottles, water, food coloring, glitter, special stones, glue, small pictures of family/friends, and cooking oil. Clients can add water to the bottles and their favorite food coloring or a color that clients believe will help to calm them. Then various stones, sequins, glitter, oil, and any object of symbolic meaning to the child are added. The bottle becomes an individualized snow globe that helps clients to relax. The therapist glues the top on the bottle making the contents secure. Then the technique is processed by discussing reasons the client chose certain items and times when clients can use the bottle to soothe them. Homework can be to look at the bottle each day, taking deep breaths and focusing on relaxing.

A technique called ''Square Breathing'' (Carr, 2000) can also help clients to relax. A square drawing is divided into four sections. Clients are asked to breathe in for four seconds, hold the breath for four seconds, exhale for four seconds, and then pause for four seconds, focusing on the feeling of relaxation.

1. Breathe in for four seconds	2. Hold breath for four seconds
3. Exhale for four seconds	4. Pause for four seconds

Bullying Technique. Anti-bullying pick-up sticks can also be used in CBPT. The client is engaged in a game of pick-up sticks. In addition to earning a point for each stick clients can pick up without moving the other sticks, they earn two points for each stick successfully picked up while the therapist taunts clients with statements told to them by bullies, such as ''butt head,'' ''stink breath,'' or ''fart face.'' The therapist (teaser) can say or do anything except touch the client. The value of this technique is in helping children learn to distract themselves from the teasing and gain self-control rather than becoming reactive.

To help clients of any age feel empowerment in dealing with bullies, the therapist can place a glass of water in his/her own outstretched right hand. Ask a client to grip the therapist's arm with both hands, holding it down to prevent the therapist from lifting the glass to drink the water. As soon as clients have tightened their grip, the therapist reaches out with his/her *left* hand, lifts the glass from the right palm, carries the glass to the lips and drinks the water. Discuss with the client how this might relate to bullying: Although others try to hold you down, you can surprise them by setting yourself free of bullying by using your coping skills.

Bibliotherapy can be used with victims of bullying. Some helpful books for children on this topic are *Enemy Pie* (Munson, 2000) (clients can make an enemy pie); *The Recess Queen (*O'Neill, 2002) (clients can act out initial reactions to Mean Jean and then how Katie Sue responded to Mean Jean); and *The Meanest Thing to Say* (Cosby, 1997) (using dress-up clothes clients can pretend to be Bill and act out how Bill could respond to bully statements).

CBPT Techniques for Enabling Emotional Intelligence. Most models of emotional intelligence include self-awareness, self-regulation, empathy, and social skills elements. While attainment of these skills can be accomplished through various techniques, there are some CBPT techniques specifically relevant to this chapter.

By engaging in a verbal variation of Ping-Pong, clients can learn positive self-statements. The therapist tells the client they are going to play a game of Ping-Pong in which the therapist begins by making a positive self-statement (related to the client's concern). Then the client makes a positive self-statement. The game continues back and forth like a Ping-Pong match. This technique allows the therapist to model self-statements and gives the client experience in generating positive self-statements.

To help children learn the coping skill of delayed gratification, present the child with a piece of his favorite candy. (If the child has a food allergy or a reaction to candy, choose another technique.) Tell the child you will be right back—you have something to do for a few minutes. Tell the child if she does not eat the candy until you return, she may have two pieces of candy. Leave the room for about 5 to 10 minutes. When returning discuss what strategies the child used to delay gratification or behavior related to not being able to delay. Often children will successfully delay by using distraction techniques like singing, turning away from the candy, and/or walking around the room. Children who cannot delay often smell the candy, continue to stare at the candy, lick the candy, and/or take small bites of the candy. Help the client to generalize the learning to everyday life.

Another CBPT technique that helps clients to develop coping skills uses a rolling pin, crackers, paper, crayons or pencils. The therapist can discuss with clients concerns that frighten them. The therapist asks the client to write each fear on a cracker. Discuss with the client their strengths and list these on a piece of paper. Wrap the paper around the rolling pin and securely tape it. Place a cracker on a table and ask the client to review the strengths on the rolling pin. Discuss how theses strengths together are stronger than the fear. Roll the rolling pin over the cracker, crushing the cracker. Do this with the other fear cracker. Save a few fear crackers and ask the client to blow away the cracker. It can be done but not as easily as crushing the cracker with the strength roller. Process how the client can mobilize strengths to overcome fear and cognitive distortions.

S.N.A.P. (Frey & Fitzharris, 1999) is an acronym that can also help clients to reduce cognitive distortions. It stands for Stop Now And Pause. Clients are asked to monitor their self-talk. When it is false and/or a distortion, clients can snap their fingers as a reminder to stop now and pause for reflection. SNAP can help clients disengage from triggers that could be problematic. After doing SNAP, clients can change self-talk to enable them to be in control of their feelings.

Using Magic to Develop Coping Skills

The novelty and fun associated with magic offers therapists opportunities to engage clients in coping skills techniques. Clients who are resistant to therapy and/or are in denial often will participate in magic techniques. This type of magic needs to be easy to learn, involve safe materials that are accessible to clients, and most importantly, have embedded metaphors that relate to the client's concerns.

An example of a CBPT magic technique requires eggs, two bowls, and a pen. Provide a bowl of eggs with negative self-talk statements written on them, such as, "This is your brain; it calls you 'stupid.'" Ask the client to make the eggs spin and dance (the eggs will not do this). Then provide a bowl of eggs with rational self-talk statements written on them, such as, "This is your brain; it tells you 'you are loveable.'" Ask the client to make these eggs spin and dance (the eggs will dance). Repeat the process with messages written on the eggs that are related to the client's negative self-talk and/or cognitive distortions, and also examples of positive self-talk. Discuss how the positive self-talk and/or rational thinking can empower the client, while negative self-talk debilitates. The magic trick involved in this technique is that the positive self-talk eggs are hard-boiled and thus will dance.

The therapeutic metaphor of effective problem solving is embedded in the following magic trick. The therapist places a dollar bill on the table and sets a glass of water on top of it. Challenge the client(s) to remove the dollar without touching the glass with anything. The trick is done with the dollar bill itself. The therapist rolls the bill from the end, forming a compact cylinder. As the fingers approach the glass, move them so they will not touch the glass as the rolling process continues. The tightened center of the dollar bill pushes the glass ahead of it, drawing the rest of the bill from beneath, thus freeing the bill. The therapist can discuss with clients the power of creative problem solving. Although a client may feel stuck in a given situation, there are always problem-solving solutions. Just as the therapist teaches the client the magic of this trick, therapy can help clients discover new problem-solving strategies. Clients learn that barriers to their self-improvement can be removed if they develop problem-solving skills.

Another problem-solving magic trick with a potato and a straw can be used with clients to help develop rational thinking about developing coping skills. Clients are asked to push the straw into a potato. After several attempts, they will not be successful at this task. The therapist then folds over one end of a straw and pushes it into the potato. The straw will enter the potato because of the compressed air in the straw, the result of closing one end of the straw. The relationship between this magic trick and clients' lives is that often when people feel they cannot solve a problem or they do not know any better coping skills, through interacting with others they are able to overcome these obstacles. Seeking others' input and feedback is a good strategy.

CASE STUDIES IN CBPT

The following case studies are representative samples of how CBPT can be used with clients of varying ages. Many of the techniques previously discussed will be interpreted into these cases. The cases follow the CBPT model of the assessment phase, middle phase, and termination phase.

Case of Bug Phobia

A four-year-old boy, Jason, was referred by his parents because of a bee and flying insect phobia he had. The boy had accidentally stepped on a beehive when he was 18 months old. He was severely stung. At age three he accidentally stumbled upon a wasp nest and was stung 25 times. Subsequently, his anxiety about anything flying, including flies, was augmented. The parents reported great difficulty in taking the child outside, even for a walk, because he was extremely afraid that some flying creature would come along and sting him. Just a brief walk around the block became impossible. The precipitating event for referral was a large company picnic at the father's place of employment. When a fly passed by the child, he let out a blood-curdling scream, which drew the attention of all the adults within hearing distance. The parents realized the anxiety had reached such a phobic stage that the child needed to be seen for treatment.

The child manifested extreme anxiety even before entering the therapist's office because the pathway to the office was lined with yellow day lilies. Although no bees, flies, or other flying creatures could be seen, the child had a paired association of flowers and bees. He was extremely reluctant to pass by the lilies, but eventually walked to the office door. This in vivo demonstration provided the therapist with an excellent opportunity to assess the child's anxiety in action.

After establishing rapport with the client by discussing events other than those involving flying insects, the therapist attempted to engage the client in the sandtray in which there was a plastic fly. The child would not even look at the fly and backed away. The therapist introduced an animal puppet based on the four continua previously discussed in this chapter. It was the therapist's belief that it would be safer and less threatening for the child to develop a desensitization hierarchy using other animals—especially a different species—to further discuss the fear. The therapist's animal puppet and the child's animal puppet developed the following hierarchy:

1. Looking at a plastic play fly from across the room. (He had never been hurt by a fly, but his fear had generalized to almost all flying creatures.)
2. Looking at a plastic play fly from two feet away.
3. Looking at a plastic fly while standing next to the sandtray containing it.
4. Touching the fly.
5. Holding the fly for a few seconds.
6. Holding the fly for a minute.
7. Looking at the fly and a plastic play bee from across the room.
8. Looking at the fly and a plastic play bee from two feet away.
9. Looking at the fly and plastic bee while standing next to them in the sandtray.
10. Touching the plastic bee.
11. Holding the plastic bee for a few seconds.
12. Holding the plastic bee for a minute.

13. Playing with the bee and the fly in the sandtray.
14. Making up a story about the bee and the fly. (Goal included obtaining an assessment of the client's self-talk.)
15. Looking at pictures of a bee in a book.
16. Looking at pictures of bees in a book.
17. Looking at bees on TV or a video.
18. Going on a one-block walk with the possibility of a bee, wasp, or fly being present.
19. Going to the park for a picnic with food that could draw bees, wasps, or flies.
20. Going to a garden.
21. Going to the arboretum.
22. Going to a beekeeper's home to visit a hive.

The therapist puppet modeled looking at the plastic fly while the child puppet watched. The therapist puppet verbalized self-statements incompatible with anxiety, such as, ''Relax, I'm okay, I am safe.'' At hierarchy step three the therapist puppet learned square breathing (reviewed earlier in this chapter). The child puppet also learned square breathing. This relaxation technique was paired with the puppet response to the hierarchy and the positive self-statements continued. Through shaping and positive reinforcement the client eventually began to touch the play bee himself. At each step of the hierarchy, square breathing and positive self-statements were used by the child, and the therapist provided modeling and positive reinforcement. At steps 18 through 22, the parents also modeled positive self-statements, used square breathing, and provided positive reinforcement.

At step 20, imagery rescripting was introduced. The child and the therapist discussed the child's thoughts about bees and feelings of helplessness. The child was encouraged to imagine himself as strong and in control. The bee was portrayed (imaged) as weak, tiny, and not as smart as people. The child and therapist developed a brief story about a boy and bees with the therapist and child using pictures cut from magazines to illustrate a storybook. This storybook was then used by the parents to encourage generalization of therapy gains and to prevent relapse. At this point the child was using the self-statements ''I am calm. I am brave.''

When the child, parents, and therapist agreed the child was ready to visit an active hive, the therapist conducted a pre-visit session in which the therapist puppet modeled relaxation and positive self-statements in the presence of many play, plastic bees in the office. At the hive the parents and therapist modeled relaxation, as did the beekeeper.

Throughout the desensitization process, the pace was largely determined by the child. At steps 10 and 19 there were slight regressions. Differential reinforcement of other behavior (DRO) was used at these steps as well as increased positive reinforcement from the brave puppet.

The case was terminated when at two-, four-, and six-week intervals the child was able to maintain and sustain the new behavior. Parents were encouraged to continue positive reinforcement, modeling, and use of the bibliotherapy materials created in therapy.

ANGER MANAGEMENT CASE

In another case a four-year-old boy was referred for anger management. He had been sexually abused by his father who, as a result, was incarcerated. When released from prison, the father was given supervised visitation with the child. Although the child had considerable anger due to the abuse, this anger was exacerbated and augmented by the parental visits.

Since the child was so young, a formal assessment of his anger did not occur. The child, however, manifested his anger during his second therapy session when he engaged in sword play with the therapist. The sword play between the two continued until the child stabbed the therapist in the chest, proclaiming the therapist to be dead. After also stabbing the therapist in the groin area, the child stated, ''There, I stabbed you in your penis, too!'' It was believed that the anger in his sword play was related to his anger toward his father and the sexual abuse.

The client expressed an interest in clay play during the middle stage of therapy. He made an image of his father and squashed it repeatedly. Puppets were used to challenge cognitive errors helping the child to realize that the abuse was not his fault. In the puppet play, irrational beliefs were also corrected; the therapist puppet informed the child puppet that although he had been hurt, he would be protected now and would not be hurt by his father. By using the ''Fist Friends'' technique discussed earlier, the therapist modeled positive self-statements. The child then engaged in Fist Friends, modeling the therapist's self-talk.

Bibliotherapy was also used with this client. Brief stories about other abused children were read to him, thus enabling him to realize that other children have also been molested and felt the same way. These stories also helped to desensitize the child to the anxiety related to the abuse.

Finally the child and therapist created a play using dress-up clothes. The theme of the play was about understanding abuse and knowing what coping skills to use. The play was videotaped to enable the therapist to offer positive reinforcement to the child for effective coping skills and to allow the child's mother to use the video for relapse prevention. At termination the mother was advised that, although the child was managing his anger more effectively and had reduced his cognitive distortions, these concerns may need to be addressed again as the child matures and experiences more advanced cognitive and sexual development.

Resistant and/or In-Denial Clients

The following case study is an example of the effectiveness of play therapy with clients who are resistant and/or in denial. This case is also an example of the use of CBPT with a 12-year-old, not a preschooler, as is often discussed in CBPT. The case also illustrates using CBPT for the same dynamic—anger—as in the previous case but with different techniques due to the developmental level of the client.

A 12-year-old girl was referred for anger management concerns. Her parents reported that she had not had difficulties of this nature before and had generally been an easy-to-manage child. With her entry into middle school she became more and more defiant of parental guidance. The parents believed part of the problem was related to puberty, and therefore, did not refer her for counseling even though she became increasingly defiant to their guidance. She frequently informed them she was going to one location with a friend whose parents picked her up and then went to another location. At sleepovers she would also change locations, usually roaming through town between 2 AM and 6 AM. She refused to do homework even though she had been an A-B student in grade school. She often arrived home after her curfew, and told other parents she could stay out later than she was actually allowed.

The parents reported that, as a grade-schooler, their daughter did not need much discipline inasmuch as she was usually compliant. When these behaviors began to manifest themselves, the parents began to be more assertive in their parenting approach, usually giving their daughter a lecture. Since lectures were not effective, the parents sought counseling.

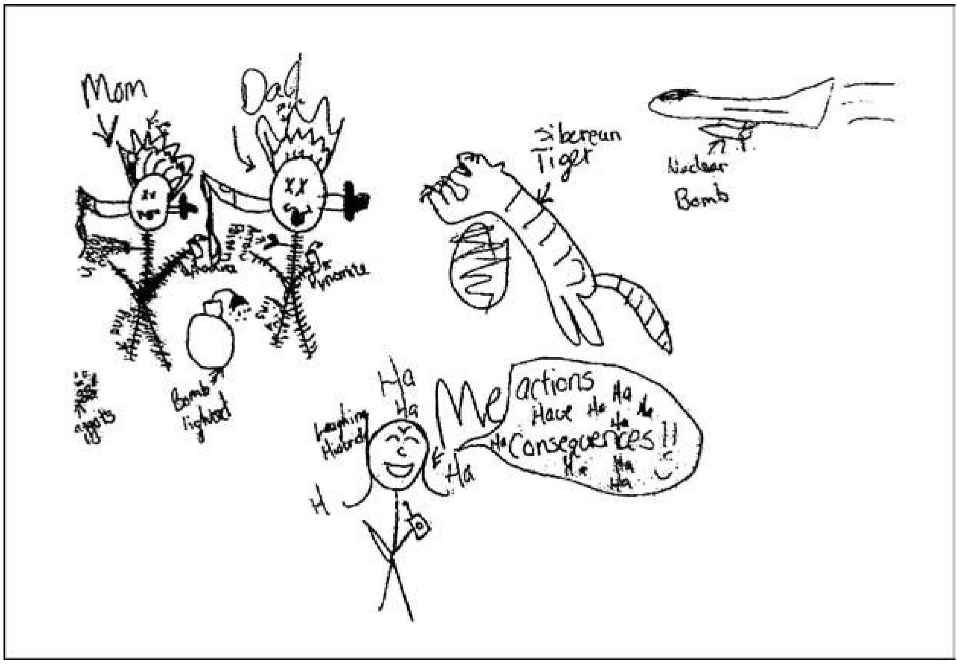
When the child was interviewed by the therapist, she insisted she did not have any anger ever. She claimed the referral was ridiculous, and she was not going to cooperate. Sensing this resistance and denial, the therapist began to use a CBPT technique.

The client was given 10 pennies and asked to stand each of them on their sides in a row. When the client perceived this as a game, she agreed to respond. This technique is designed to assist therapists in understanding the particular self-talk of the client as she escalates her frustration and anger. While this is a challenging task, it can be accomplished by clients as young as six and as old as 85-plus, provided no countervailing physical problems exist. This technique is helpful in the assessment phase of CBPT.

During the technique, the client first insisted that it could not be done. Much of her self-talk was around ''This is impossible. It can't be done. This must be a trick.'' When encouraged to continue, she finally stood two pennies on their sides. Therapists need to give the exercise ample time in order to experience the client's total repertoire of frustration self-talk. Therefore, the therapist encouraged the client to continue. After a few more attempts, her responses were, ''I can't do this; this is stupid.'' She eventually stood up three more pennies, although her self-talk eventually increased to ''You made this too hard. You expect too much from me.'' After this she threw all the pennies on the floor.

The parents were encouraged to give the daughter consequences for noncompliant behavior and to use fewer lectures. Between the first and second sessions with the child, the parents gave her consequences for coming home late and changing locations. Before the next session the father called the therapist to inform her that he had found a drawing on his daughter's bed that morning which disturbed him immensely. (See figure below) He wanted to fax it to the office immediately.

The drawing depicted the parents being stabbed through the head with very large swords, poison arrows all over their bodies, maggots on their bodies, and dynamite in their hands. Their hair was on fire and an ignited



bomb was between the two of them. A Siberian tiger and a nuclear bomb were also attacking them. The girl drew herself with the remote control for the dynamite in her hand, while she was laughing hysterically, and saying, ''Actions have consequences!''

The father was concerned that his daughter was going to actually stab her parents to death that night. The therapist inquired about the precipitating events to the drawing and was informed that the parents had grounded her and told her, ''Actions have consequences.''

This drawing, while alarming to the parents, served as an excellent assessment tool for the therapist and enabled the therapist to understand the cognitive distortions the child had, such as ''My parents can't control me,'' ''I'm all powerful,'' and ''I can do what I want.'' All the distortions were overcompensation for feeling inadequate and unable to meet the parents' expectations. (This was also evidenced in the penny technique.) It also served as a tool to assist the therapist in calming the parents, since the drawing was seen as a catharsis for the child's anger.

In addition to the Ten Pennies technique and the family drawing, the therapist also used the Anti-Coloring Book with the client. When she came to therapy the drawing was discussed, and she was asked to respond to an Anti-Coloring Book page on which the stimulus is, ''Have you ever felt like punching someone?'' She thought of these play therapy techniques as ways of not being cooperative since the process was different from traditional talk therapy. She drew herself punching out her parents, while verbalizing that they expect too much from her and they are mean.

In the middle phase of CBPT, the ''Call-in Talk Show'' (Kaduson, 2000) technique was used. The client's advice was initially maladaptive, such as, ''Just scream, throw things and/or threaten to run away.'' As the therapist modeled prosocial anger management techniques as they switched roles in the talk show, the client eventually gave more prosocial advice to the caller. The therapist frequently called in wanting advice about how to deal with authority figures and how to manage anger since these were concerns of the girl.

''Balloons of Anger'' (Kaduson & Schaefer, 2000) was also used with the client. Following this activity a discussion ensued about positive self-statements to use to allow the anger to dissipate slowly, rather than build up to a rage. Several positive sessions took place on this topic with positive reinforcement being given by parents and therapist for using the statements.

To help the client relax, the Soothing Bottles and Square Breathing techniques were used. Square breathing was also taught and recommended to the parents.

Angry outbursts between the parents and child subsided even while the parents continued to give consequences for inappropriate behavior. The child used her positive self-statements, coping skills, and relaxation skills. Positive reinforcement continued from the parents and the therapist. The client was encouraged to give herself positive reinforcement in her self-talk also.

In the termination phase, to assist with relapse prevention, the client was asked to write a letter to herself listing the various coping skills she had learned for anger management, and what she would have to do to continue to use them. This letter was sealed in the office and mailed to her two months later as a reminder to continue the new behavior.

This case also is an example of CBPT being used in developmental therapy as well as remedial approaches. This client was responding with difficulty to the developmental tasks of her age. Her parents had to adjust their parenting style from lectures to actions to accommodate these developmental styles. While this case could have evolved into actual violence and become much more clinical, the therapeutic intervention prevented this.

SUMMARY

In this chapter the value and uses of play therapy, especially CBPT, have been reviewed, appropriate client populations have been discussed, four continua to use as a mandala with clients have been posited, and numerous CBPT techniques have been reviewed to aid clients with self-esteem, coping skills, and cognitive distortions. What becomes more and more evident as therapists use CBPT with clients of all ages is what Henry Ford said many years ago: ''Whether you think you can or think you can't, you're right.''

It is hoped that the information herein helps therapists to aid their clients in not just thinking they can but also translating these thoughts into behavioral change.

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CHAPTER 19

Playful Strategies to Manage Frustration: The Turtle Technique and Beyond

EVA L. FEINDLER

EMOTIONAL COMPETENCE IN CHILDREN

Recently, attention has been focused on the fundamental role of emotional competence in children's development. The ability to understand the meaning of emotions, the ability to express emotions, and the ability to regulate emotions are all key to every child's adaptive social functioning (Havighurst, Harley, & Prior, 2004). In 1999, Saarni proposed a model of emotional competence that emphasized cognitive and social moderators and identified some key skills, such as awareness of one's own emotions, the ability to discern the emotions of others, and the capacity to cope adaptively with difficult emotions (Suveg, Southham-Gerow, Goodman, & Kendall, 2007). Others have focused on children's emotion dysregulation as a risk factor for various aspects of child psychopathology (Keenan, 2000), and many intervention or prevention programs for young children now include an emotion-focused component. For example, Izard, Trentcosta, King, and Mostow (2004) have developed an Emotions Course for Head Start Children. Using a variety of puppets and vignettes, teachers conduct 22 sessions of affective education about the emotions of happiness, sadness, anger, and fear. Results from pre- and postcourse assessments indicated that children increased their knowledge of emotions and improved in this emotion regulation.

One of the most comprehensive programs designed to strengthen both the emotional and social competence of young children is the Dina Dinosaur Program developed by Carolyn Webster-Stratton and her colleagues. This small-group program emphasizes training skills such as emotion literacy, empathy and perspective taking, friendship and communication skills, anger management, and interpersonal problem solving. This 20-week program, designed for children with conduct problems, is geared to children between the ages of 4–8 years and in the preoperational phase of cognitive reasoning. Cognitive, affective, and behavioral components are integrated, and children are exposed to puppets as models, videotaped vignettes, role-plays, fantasy play and much coaching, cueing, and reinforcement by others. Program evaluations have indicated both short-term and long-term effectiveness with clinic-referred young children and effectiveness is enhanced when this child program is implemented in conjunction with the correlated parent training program, The Incredible Years (Webster-Stratton & Reid, 2003). This is one of the only programs to include a special emphasis on anger management, which I will detail in a later section.

Within a cognitive behavioral theoretical model, an anger experience is viewed as a subjective experience varying in intensity and duration and as emerging in a variety of interpersonal contexts. Anger expression, viewed as the ability to act on anger by showing it outwardly, suppressing it, or actively coping with it, varies between individuals (Sukhodolsky, Kassinove, & Gorman, 2004). Anger, as one of the many emotions children learn to master, is a complex emotional construct composed of physiological, cognitive, and behavioral components. For young children, the link to aggressive behavior is fairly common (Larson & Lochman, 2002) and most children learn to control their aggression and express their emotional experience in a socially competent fashion.

However, there are significant numbers of children who fail to achieve the skills of emotional regulation and impulse control who will then need particular clinical attention as early patterns of aggressive behavior tend to remain stable across time.

ANGER AND AGGRESSION IN YOUNG CHILDREN

Aggressive behavior problems in young children are one of the most frequent referral issues for clinicians, and since early patterns may predict later antisocial behaviors, early interventions seem fundamental. Many risk factors that lead to the development of anger and aggression problems have been identified. These include a difficult or uninhibited temperament, deficiencies in affect regulation and social information processing, hostility biases and misappraisals, and poor problem-solving skills. Contextual risk factors have focused on parents who provide harsh discipline, poor monitoring, and inconsistent contingency management (Feindler, 1995). Coercive patterns of family interactions and the absence of positive parenting behaviors are also influential variables (Davenport & Bourgeois, 2008) in the development of aggressive behavior patterns.

Emotion regulation, in particular, the regulation of anger and frustration, influences the occurrence of cognitive and social skills necessary for prosocial functioning. Young children who exhibit aggressive behaviors most likely experience intense levels of negative affect and have few internal coping skills to manage their emotions. During the past 10 years, there has been a proliferation of cognitive behavioral anger management intervention programs. Based on the understanding that children's aggressive behaviors are the outcome of poor emotion regulation and self-control, programs have been developed to remediate these deficits. If children's emotions and subsequent actions (in this case anger and aggression) are regulated by the way they perceive, process, and/or mediate environmental/interpersonal events, then their experience of frustration and anger is related to identifiable deficits and distortions in this social information processing sequence. Further, there may also be deficits in problem solving and appropriate anger expression skills. Thus, a child will need to learn ways to manage their subjective emotional experience, to reframe his or her cognitive appraisals of events, and to respond to provocation in an effective prosocial manner (Feindler & Gerber, 2008).

A comprehensive meta-analysis of cognitive behavioral therapy for anger in children and adolescents was reported by Sukhodolsky et al. in 2004. Their review of 40 outcome studies indicated a medium effect size overall and a greater effect size for programs with an emphasis on behavioral skills development then those emphasizing affective education. However, despite the large number of subjects ($n = 1953$), the age range of children was from 7–17.2 years with a mean age of 12.5 years, and the effect size for studies with older subjects was greater. Clearly, these results cannot be generalized to intervention programs for younger children. (Sukhodolsky et al., 2004).

A more recent review of the literature (Blake & Hamrin, 2007) details a variety of anger management approaches for children. These include attribution retraining programs, such as the Brain Power Program for children in grades 3–6 (Hudley et al., 1998), the Anger Coping Program for children ages 9–12 (Larson & Lochman, 2002), the Aggression Replacement Program for teens (Goldstein & Glick, 1994), and other multicomponent programs (Feindler & Guttman, 1994; Deffenbacher, Lynch, Oetting, & Kemper, 1996; Sukoholdosky, Solomon, & Perine, 2000). Research on these programs is extensive, and the outcomes are quite promising; however, there are no published reports of anger management interventions for children under the age of 7.

ANGER MANAGEMENT APPROACHES FOR YOUNG CHILDREN

Since the current anger management strategies have not yet been extended to nor evaluated with populations of young children, we need to look a bit further at aspects of child development germane to treatment planning.

THE ROLE OF PLAY

Children's pretend play has long been proposed as a mode of social interaction that enhances the development of emotion regulation (Gayler & Evans, 2001). Pretend play provides children with a unique environment in which to practice and master social and emotional skills. According to Fein (1989) pretend play, by transcending literal meaning, provides a context to process, manifest, and modify experiences involving high levels of emotional arousal. Themes and stories acted out in play help to teach display rules about emotions, such as when and how to express anger as well as model aspects of modulation of emotions (Gayler & Evans, 2001). Clearly, play is a learning mode for young children and should be incorporated into any clinical intervention. Abstract forms of play allow for the attuning of motivational states, emotional reactions, and social cognition (Peterson & Flanders, 2005).

Many aggressive young children have difficulty playing imaginatively and instead release their aggressive impulses by hitting, throwing, breaking, biting, and so on during play. Further, they seem to have difficulties engaging in rich or complex play and in coordinating symbolic play themes (Landy & Menna, 2001).

Opinions vary as to the availability of aggressive toys in clinical settings when working with young aggressive children. Some therapists see the use of toys, such as the punching bag or Bobo doll, as necessary to a child's behavioral expression of emotion and underlying conflict (Trotter, Eshelman, & Landreth, 2003), while others see aggressive toys as possibly harmful. Schaefer and Mattei (2005) in their review of catharsis and children's aggression concluded that "when adults permit and encourage children's release of aggression in play, the children are likely to maintain this behavior at its original level or actually increase it" (p. 107). Therefore, many therapists would rather incorporate the use of structured play to teach children numerous affect expression and regulation skills as well as teach children how to control aggressive impulses. Drewes (2008) conceived that the use of the Bobo doll and other aggressive toys is not effective and recommended alternative expressive material as providing a more constructive and perhaps symbolic means to express emotions. Unfortunately, little recent research comparing these cathartic strategies with other play therapy strategies when working with young aggressive children has been done.

The Role of the Parent

There are many aspects of parenting documented as key to the development of social and emotional competence in young children. Parent regulation and expression of their own emotion, parents' reactions to their children's emotions and parents coaching and discussion of their children's emotions all contribute to the developing child's emotion understanding and the ability to regulate emotions (Harvighurst et al., 2004). In addition to this key role in teaching aspects of emotional competence, there are many parent responses seen as pivotal in the occurrence of children's aggressive behavior problems, and therefore, parents must be included in any comprehensive treatment approach.

Davenport and Bourgeois (2008) provide a comprehensive review of both negative and positive parenting characteristics that influence preschool children's aggressive behaviors. The presence of negative characteristics, such as inconsistent, ineffective, and harsh discipline strategies, and patterns of negative attributions assuming intent and resulting in blame for child misbehaviors has been identified in families with aggressive children. In contrast, parents who balance firm discipline with warmth and support and who generate proactive, preventive strategies for dealing with child misbehavior are providing a healthy context for the developing child (Davenport & Bourgeois, 2008). In fact, sophisticated mother-child conversations about emotions appear to lay the groundwork for both the child's understanding of affective states and the emergence of the ability to adopt the perspective of another (Peterson & Flanders, 2005). This ability to be empathic is a key modulator of anger arousal and its absence is hypothesized to influence the occurrences of aggression.

It seems logical then that any program targeting children's emotion regulation and/or dysregulation have an active parenting component. Harvighurst et al. (2004) describe the Essential Parenting Program, a six-session group program for parents of four- and five-year-olds. Their program is based on the assumption that if parents respond supportively to their children's emotional experiences and coach them in ways of handling their feelings, the children will develop emotion understanding and regulation skills. Some of the parent skills trained include labeling emotions, viewing emotions as a time for intimacy and teaching, empathizing and validating children's affective states, and problem solving around emotional events. Results from a pilot program evaluation indicate improvements in parent reports about their own responses to their children's emotions and about reductions in children's behavior problems. Although results are encouraging for this creative and valuable parenting approach, additional observational data on parent-child interactions during emotional events is really necessary to understand the full impact.

A slightly different emphasis in some parenting programs is on parent-child play as the context for change, and this is certainly relevant for young children who can use play as a method of expression and affect regulation. For the most part, parents are active participants in their child's play as it helps facilitate affective understanding, provides opportunities to teach prosocial skills, and supports the positive affective attachment between parent and child (Davenport & Bourgeois, 2008).

There are many, many effective parent training programs available for parents of young children, and they vary according to specific behavioral foci as well as format and techniques incorporated. Parent Child Interaction Therapy (Eyberg, 1988) teaches parents behavior management strategies along with problem solving and play skills for enhancing the positive connections between parents and their children. More recently, Dumas (2005) has proposed a mindfulness-based parenting approach that emphasizes parents' awareness of their own affective states and incorporates a conscious decision-making aspect of responding. Aside from the RE-THINK program described later in this chapter, few parent programs focus specifically on anger management for parents and their children.

One family-based intervention for anger management was reported by Greene, Ablon, Monuteaux, Goring, Henin, & Raizer-Blakely (2004) and study participants included some younger children (ages 4–12, x age = 7). Their collaborative problem-solving approach teaches parents to understand cognitive mediators of their children's aggressive behavior and to implement several problem-solving strategies during conflicted parent-child interactions. Initial data indicate large effect sizes were maintained at a four-month follow-up, although assessments were limited to parent self reports.

In summary, there has been a great deal developed for those who work with young children with difficulties in emotion regulation and aggressive behavior. With a focus specifically on anger management for young children, there has been limited research on the most effective intervention strategies and program elements. Most likely, effective treatment would incorporate a number of play therapy strategies as they are quite effective in general for preschool children (Bratton, Ray, Rhine, & Jones, 2005; Hall, Kaduson, & Schaefer, 2002), would be disseminated in an individual or small-group format for children who are clinically referred, and would include a parent training component specific to anger management. The next section will review some anger management play therapy ideas as well as a parent education program designed for anger management.

PLAY THERAPY AND ANGER MANAGEMENT FOR YOUNG CHILDREN

As this brief review indicates, the cognitive behavioral anger management approach to treatment for aggressive children has been well documented. Key programs have been implemented and evaluated in both school and clinical settings. However, virtually none of these intervention programs have been extended to children under the age of 7. Given the developmental and contextual variables influencing skill development for young children, it is most probable that clinicians will need to incorporate some play therapy strategies as well as to consider anger management interventions with the parents of these children.

BIBLIOTHERAPY

Young children are easily engaged with adults via the use of storybooks. There are currently many books appropriate for young audiences that focus on learning about anger or frustration and the variety of ways that children can learn to cope with anger. Table 19.1 lists the most commonly used books on this topic for young children.

There is some evidence that bibliotherapy may assist in clinical work with young aggressive children as it assists children in learning self-control by identifying with others and finding both unique and universal solutions, (Schechtman, 2006). In a unique program with eight-year-old aggressive boys, Schechtman (1999) incorporated short stories, poems, films, and pictures to assist in the identification of motifs associated with aggression (see article for full listing of bibliotherapy resources; however most are only available in Hebrew). Integrating small-group play activities with the conflicts the characters faced in each narrative, Schechtman (1999, 2006) highlights several objectives of this affective bibliotherapy. These

Table 19.1

Resources for Children Ages 3–8

Commonly Used Story Books	
M. Agassi (2000) *Hands Are Not For Hitting*	
E. Crary (1997) *I'm Furious*	
J. Cain (2000) *The Way I Feel*	
M. Garrett (1999) *When Sophie Gets Angry—Really Angry*	
L. Namka (2005) *The Mad Family Gets Their Mads Out*	
G. Ditta-Donahue & A. Blake (2003) *Josh's Smiley Faces: A Story About Anger*	
L. Shapiro & S. Harpster (2004) *Arnold Gets Angry*	
C. M. Spelman (2000) *When I Feel Angry*	
Anger Activities and Games	
L. Schapiro & F. Rubinstein (2006)	Smart and Angry Games—CTC
L. Schapiro & F. Rubinstein (2006)	Escape from Anger Island—CTC
J. Simmons (2003)	Seeing Red
E. Pill (2005)	Everybody Gets Angry
G. Gaynor, K. P. Ray & M. Schexnayder (2003)	Helping Your Angry Child: A Workbook For You and Your Family

include helping children to reflect on their aggressive behaviors, understanding triggers for the characters, connecting to one's own experience, and recognizing negative outcomes. Results from pilot clinical studies suggest that literature can facilitate insight and skill development, while stimulating curiosity and minimizing defensiveness (Schechtman, 1999). In a larger program implemented in a school setting, this bibliotherapy approach also served to enhance empathy as children focused on the character's emotions as well as on the motives for behaviors that combined to provide a model for empathic interaction (Schechtman, 2006).

Turtle Magic is a short children's story designed to highlight several main components of anger management for young children. Based loosely on the turtle-technique described by Robin (1976) as an effective classroom strategy for assisting young children in impulse control, the story is 10 pages long with colorful illustrations. Basically, the story follows Timmy Turtle who has some problems adjusting to school and getting along with other children. His repeated aggressive and impulse behaviors result in Timmy being asked by his teacher *not* to come to school. Continuing to be frustrated, but now also lonely, Timmy is advised by a grandfatherly turtle to use the shell on his back to create a safe space to relax and think about solutions to his problems. Thus ''Doing a Turtle'' depicts a four-step process of anger management: (a) recognizing anger as it swells, (b) interrupting the swell and pulling inside, (c) taking a few deep breaths and thinking about how to solve the conflict, (d) returning to the scene and implementing a possible solution.

Turtle Magic can be expanded upon as children can develop other adventures for Timmy Turtle and as the four-step problem-solving model (Spivack, Platt, & Schure, 1976) can be applied to individual as well as group issues serving to elicit frustration responses from young children. Via storytelling about Timmy children can develop their narrative abilities, which helps them view situations from multiple perspectives and enhance their capacity for empathy (Peterson & Flanders, 2005). (See Figure 19.1 through 19.4.)

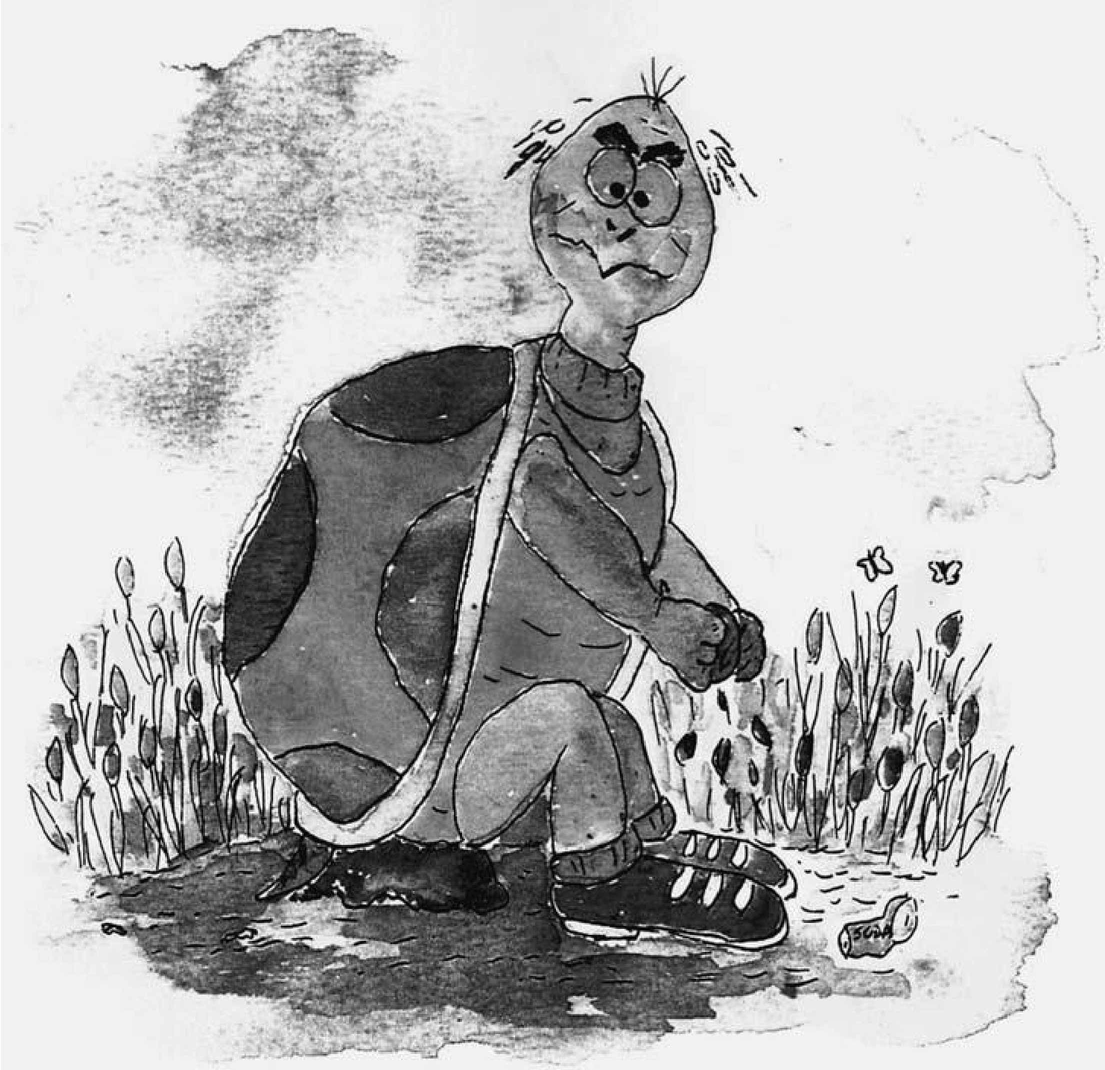

Figure 19.1 Step 1: Recognizing Anger as it Swells (Pages from *Turtle Magic*.)

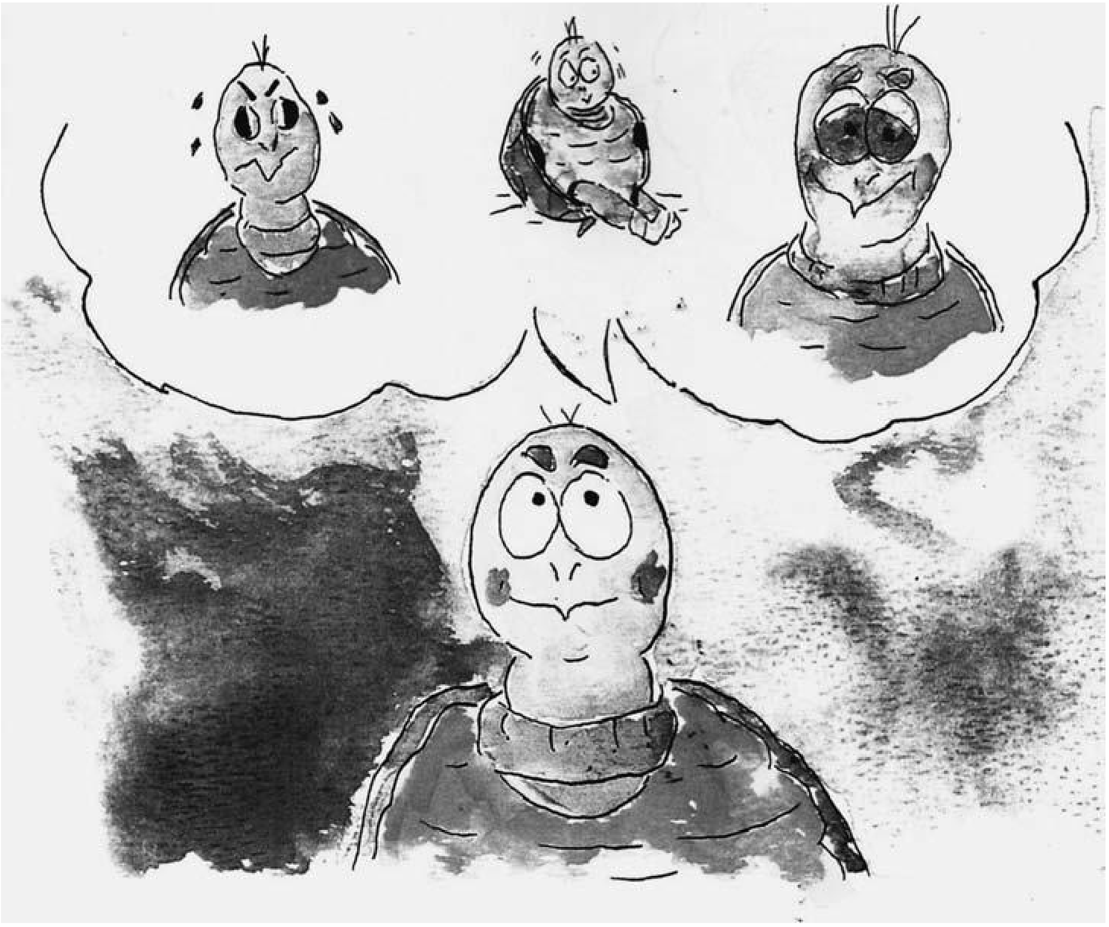

Figure 19.2 Step 2: Interrupting the Swell and Pulling Inside (Pages from *Turtle Magic*.)

PUPPET PLAY

Puppets have long been used by cognitive behavioral play therapists as a way to model cognitive strategies such as countering maladaptive beliefs and making positive self-statements (Knell, 1997). In fact, since for young children, metacognitive abilities may be limited, puppet play provides an active method for understanding children's internal language and belief systems and for teaching verbal social information processing skills that will enhance self-control. Further, puppets can play a crucial role as a symbolic client onto which children can project their thoughts and feelings (Hall et al., 2002).

Hand puppets are often used both in free play and structured ways when clinicians work with young children. Animal puppets allow children to explore imagined scenes free from gender constraints. A natural

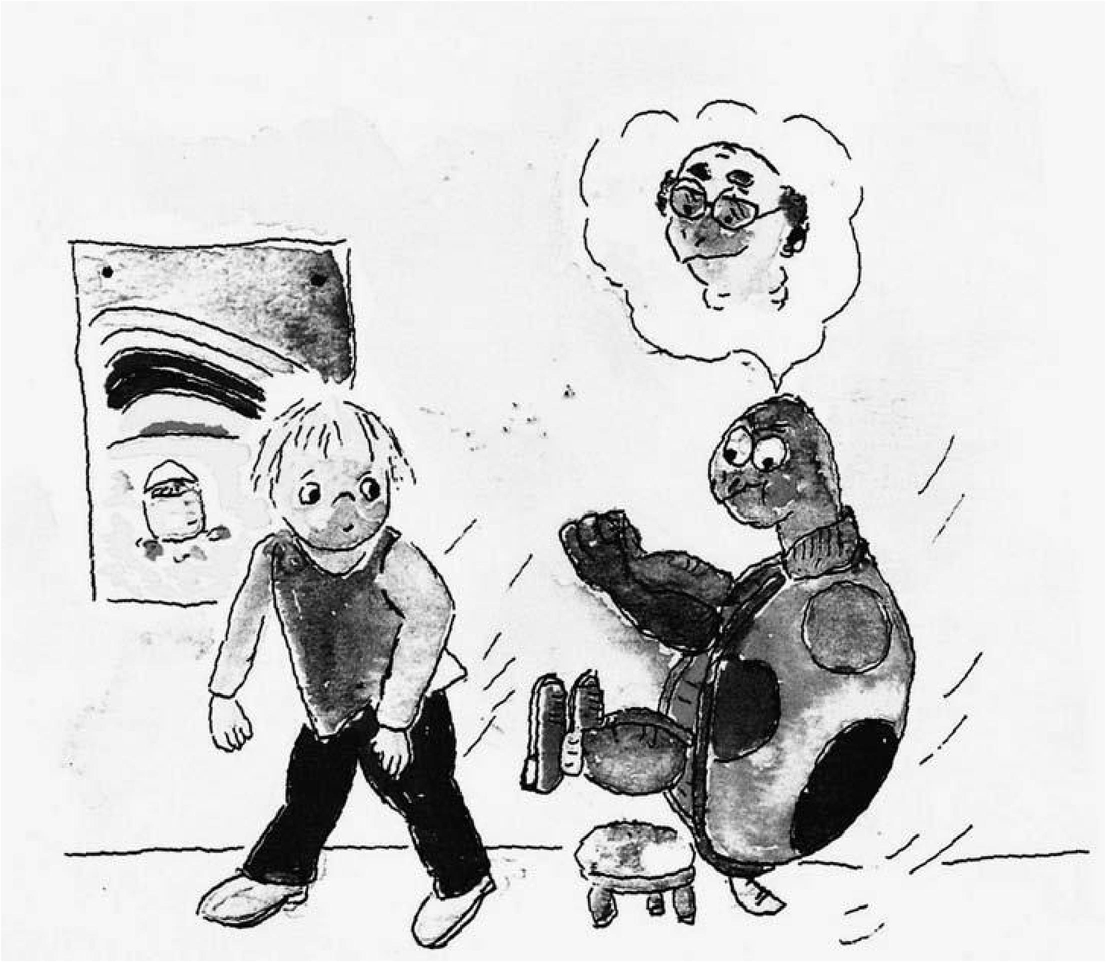

Figure 19.3 Step 3: Taking a Few Deep Breaths and Implementing a Possible Solution (Pages from *Turtle Magic*.)

extension to the *Turtle Magic* story was the accompaniment of turtle puppets to both augment the story and to allow for Timmy Turtle to have new adventures. Additionally, as suggested earlier in the ''turtle-self'' metaphor by Art Robin (1976), young children may practice the actual skills of removing themselves from provocation or conflict, moving into a safe and calm space, and thinking about solutions by modeling the actual behaviors of Timmy Turtle. Folkmanis is a company that produces a wide variety of animal puppets. Their turtle puppets allow the puppeteer to retract the turtles head into the shell in order to take some deep breaths and think things through. (See Figure 19.5.) This then can be a kinesthetic metaphor and a prompt by adults aware of a child's increasing frustration to ''Do a Turtle.''

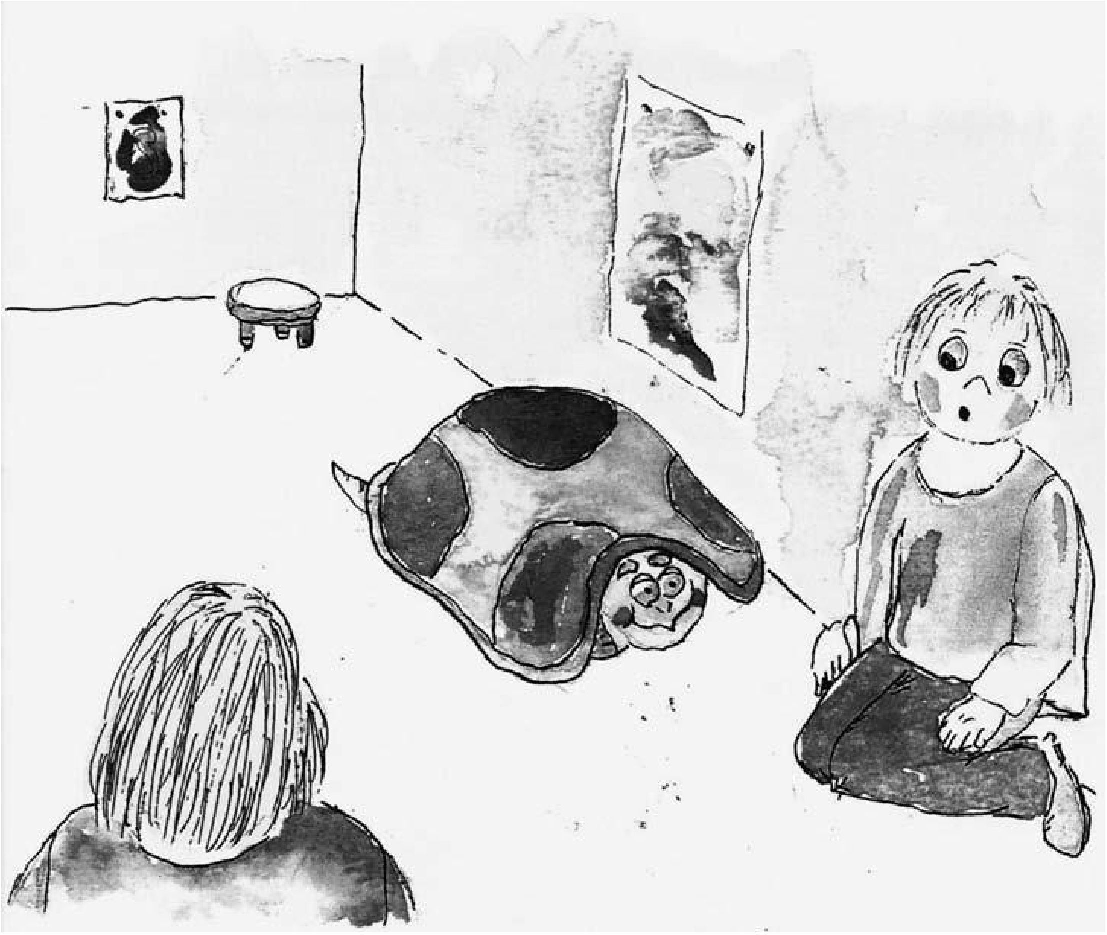

Figure 19.4 Step 4: Returning to the Scene and Implementing a Possible Solution (Pages from *Turtle Magic*.)

Larson and Lochman (2002) describe a puppet self-control task as session three of their Anger Coping Program used with 8–12-year-old children. Acknowledging that aggressive children often have critical cognitive deficiencies in the area of useful mediating cognitions to regulate anger arousal, they introduce self-control talk indirectly through the use of puppets. The individual's puppet is helped to use various thinking strategies to control their feelings and behaviors while other puppets in the group try to tease and provoke. With younger children it is recommended that this be done using simple calming prompts (i.e., ''I think I'll take a deep breath'' or ''I need to chill out'') in a one-to-one play interaction.

In the Dina Dinosaur program component designed to help young children understand and manage their emotions, Wally (a child-sized boy puppet) shares some of his secrets for calming down: take a deep

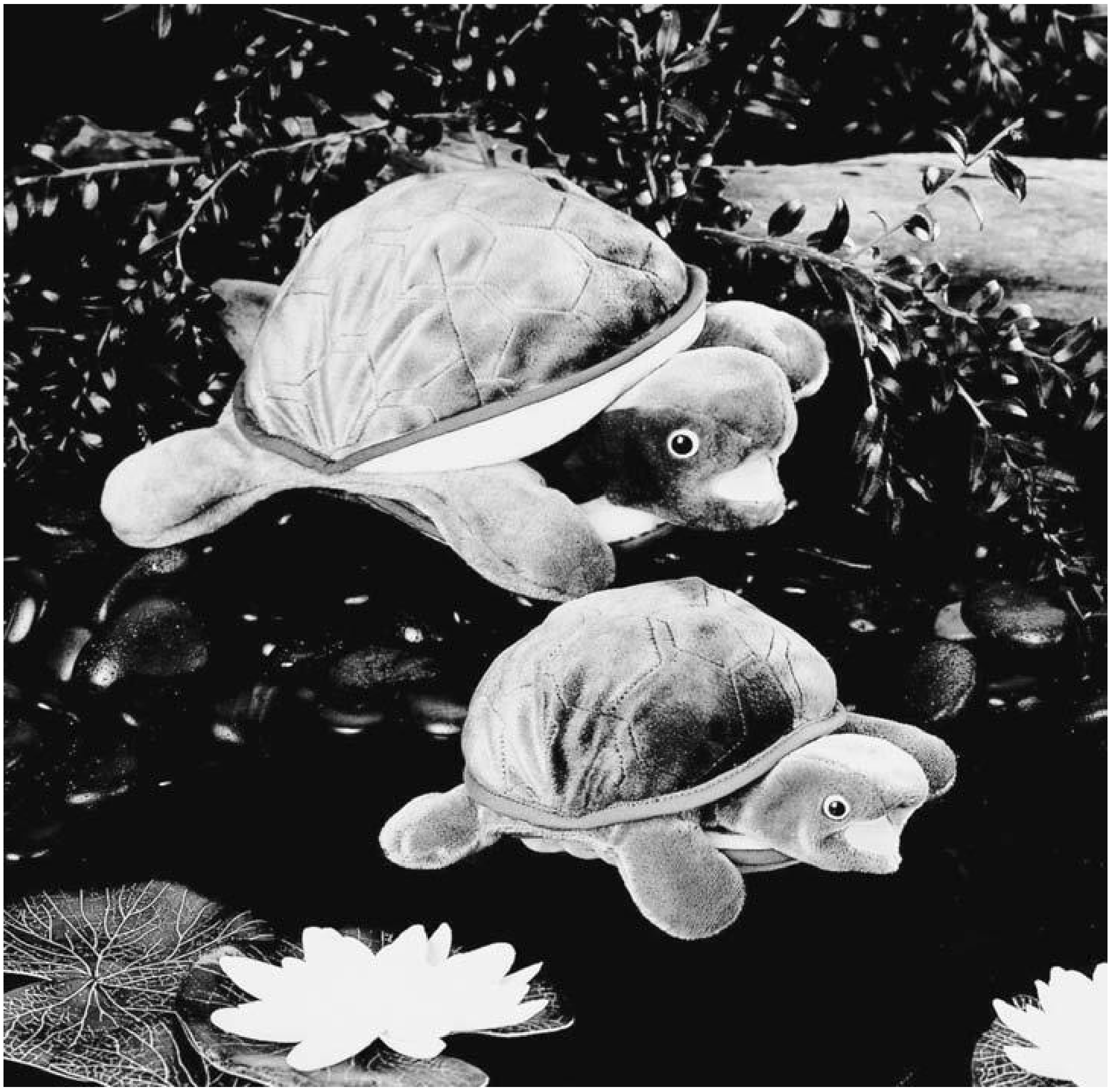

Figure 19.5 Folkmanis Turtle Puppets

breath or think a happy thought (Webster-Stratton & Reid, 2003). Wally returns in a later session to present typical interpersonal conflicts that he might have and to encourage the children to use their problem-solving skills and help him practice an effective solution. Wally also has a puppet sister, Molly Manners, who helps out with alternative attributions and teaching the prosocial skills needed for forming and maintaining friendships. Other puppets, each with a particular issue (Oscar the Ostrich, who withdraws, or Freddy the Frog, who cannot sit still), regularly visit group sessions and help to engage the children with sensitive or painful issues.

Throughout this comprehensive program to strengthen children's social competence, puppets are used to introduce context, narrate video vignettes, model prosocial skills, and enhance collaborative learning.

Finally, the Tiny Turtle puppet is used in this program to teach children a five-step anger management strategy: recognize anger, think ''stop,'' take a deep breath, go into your shell and tell yourself ''I can calm down,'' and finally try again (Webster-Stratton & Reid, 2003). Numerous activities are then incorporated to reinforce and extend the learning, and videotapes of children handling anger are shown as well.

Puppets quickly engage children visually and are often used in video materials. The Control Anger DVD (Courage to Change, 2006) is cohosted by Groark, a child-like dragon who demonstrates the skills of recognizing anger, regulating his arousal, and expressing his frustration in a prosocial fashion.

Another puppet, Audrey Duck, also plays a significant role in the anger management program RETHINK, produced by the Institute for Mental Health Initiatives (Research Press, 2000). This parent training approach was originally designed as a prevention program for parents at risk for child abuse (Grotberg, Feindler, White, & Stutman, 1991). The main components of the RETHINK program are (a) child development education in regards to appropriate parent expectations and (b) anger management skills for parents when frustrated by their children's behavior. The program is geared toward parents of young children and includes a multitude of typical parent-child conflicts that are used for in-group role plays.

The seven RETHINK skills taught to parents are as follows:

Recognize: Recognize what triggers your anger.
Empathize: Empathize with the other person and put yourself in the other person's shoes (it means listening with your heart).
Think: Think about your anger and try to ''reframe'' the situation in a way that might reduce or eliminate your anger.
Hear: Hear what the other person is communicating with their words and nonverbal actions. Hear with your complete attention.
Integrate: Integrate genuine respect in your responses. Use ''I'' statements.
Notice: Notice how your body alerts you to your feeling angry.
Keep: Keep to the present problem at hand.

The program guide (Research Press, 1991) is accompanied by a parent workbook, and both are quite educational and flexible in the formats that are used with various parent groups. Sessions are segmented by topic (in the anger management skills) and by age (in the child development portion) and include educational information, skill demonstration, discussion topics, and behavioral rehearsal guidelines. Anger triggers specific to parent-child interactions are presented along with an analysis of antecedent influences and parent responses. Further, applications of the relevant RETHINK skills are suggested. Depending upon the ages of the children being parented, role-play scenarios of angry interactions are enacted and discussed.

Figure 19.6 is a sample situation from the RETHINK parent's manual and is specific to an anger provocation scenario between parents and their young children.

Note that this scenario incorporates knowledge about child development, some functional hypotheses about antecedent triggers and interactional sequences, the application of relevant RETHINK skills, and pointers to help parents manage their own anger. The videotaped interactions between Dr. Susan Lin and Audry Duck help to illustrate concepts and reinforce the psychoeducational component (Research Press, 2000).

Other Relevant Anger Management Play Techniques Games

Hall et al. (2002) review many of the most frequently used play techniques that are designed to help children become aware of and manage their emotions to improve arousal regulation and to enhance problem-solving skills.

Briefly, the following games would be helpful in constructing an individualized anger management treatment plan for a young child:

1. *The Feeling Word Game:* a flexible word game designed to help children identify the various feelings a character in a narrative might experience.
2. *Color Your Life:* helps children further their understanding of varying affective states by matching colors to feelings.
3. *Balloons of Anger:* working with actual balloons, children are helped to understand how anger can build up inside and what would happen if it wasn't released slowly and safely. The air and the intensity of the anger experienced are equated.
4. *The Mad Game:* a block play game designed to show that anger is a common feeling and to help children express their anger kinesthetically and verbally.

Situation 6 Preschool: Fifth Year

Sam, age 5, has his heart set on an ice cream bar from the freezer. His sister, Susan, got away with taking one yesterday; their mother, Lean, didn't do anything about it when she found out. Sam wants to show that he can take the initiative, too. Sam opens the refrigerator door and is reaching for the freezer unit when Lena comes in. ''You can't have that ice cream bar now,'' yells Lena. ''Get away from there!'' ''I hate you! You're not fair!''

What is going on with 5-year-old Sam?

A child Sam's age is angry when he:

1. Is required to think of others
2. Is in competition with others or jealous of a sibling
3. Does not receive enough attention and approval
4. Is forced to follow rules
5. Is hit or yelled at
6. Has his things damaged or taken away
7. Is hurried or rushed
8. Feels others have more than he does
9. Is frustrated by not mastering a skill

A child Sam's age is learning about himself and the world by:

1. Imitating others – for example, family members or TV personalities
2. Being willing to compete and share
3. Understanding some rules of friendship
4. Understanding the family and the different roles of family members
5. Knowing what, when, and where it is safe to initiate and explore
6. Taking more initiative
7. Becoming familiar with symbols

What can Lena do about her own anger? What RETHINK skills will work?

RECOGNIZE her anger

Lena (to Sam)
- I don't know about an ice cream, young man – I'm afraid I was about to give you a big shake.

EMPATHIZE with Sam

Lena (to herself):
- Sam certainly hates being stopped. He's trying to be independent and do things on his own. I really feel for him.
- I did let Susan take an ice cream bar yesterday without asking my permission. Sam probably thought it was OK for him to take ice cream, too.

Think and RETHINK

Lena (to herself):
- I guess the old expression applies for this family: ''I scream, you scream, we all scream for ice cream.''
- I thought he really meant what he said about hating me. Well, it was chocolate ice cream.
- Sam said I wasn't fair. I guess he's feeling deprived.

Lena (to Sam):
- You can stay and tell me you're angry, but you have to go to your room if you kick me.
- Between my yelling and your kicking, we both need a time-out. Let's take a few minutes to cool down.
- You're right Sam. It isn't fair if Susan gets an ice cream and you don't. Let's come up with a family snack time.

How can Lena teach Sam about managing his own anger?

- Help Sam calm down by holding him to stop the kicking.
- Talk about anger: ''I know you're very angry. First tell me what is making you angry. Why did you say I was unfair?''
- Help Sam understand the reasons for limits: ''I don't want to let you eat an ice cream bar so close to dinner.'' ''You can ask me why I won't let you do something, and we can work it out.''
- Give options: ''Come to me first and ask for ice cream.'' ''Instead of worrying about your sister, convince me why you should have an ice cream.'' ''Put into words what makes you angry rather than kick.''

Figure 19.6 Sample Situation from RETHINK Parent's Manual

5. *Bubble Breaths:* by asking children to only blow one big bubble, children learn to take deep breaths, exhale slowly, and become aware of their mind-body connection.
6. *The Power Animal:* children create a positive hero who will accompany them and cue them to use problem-solving strategies and to think positively about themselves.
7. *The Anger Bucket* (Kaduson, 2001): the therapist can write out sentence completion cards to say ''I get angry every time________'' or ''When I get angry, I ________.'' After drawing one of these cards from the bucket, a nonaggressive solution is suggested.

DRAWING

The Anger Thermometer or Feeling Thermometer (Webster-Stratton & Reid, 2003) has long been used as a visual aide and as a drawing activity to help children estimate the intensity of their emotional experience.

In addition to providing a method to express differing degrees of anger, for older children words can be added to each level thereby expanding the child's emotion vocabulary. Crenshaw and Mordock (2005) suggest:

> At lower levels of anger, words taught could include bothered, annoyed, aggravated, irritated, irked, needled, peeved, or stung. For the boiling point, the words taught could be bang, blow up, burst, explode, rage, roar, or seethe. For points in between, the words abhor, detest, despise, hate, or loathe could be taught. (p 105)

Once a child has become aware of and labeled the intensity of his/her experience, the focus is on finding ways to self-soothe and self-calm in order to prevent a further rise in temperatures. Such arousal regulation is necessary to set the stage for the use of social problem-solving skills. Clearly, for young children, these verbal distinctions may be too complex, but the coloring in of the thermometer with a crayon matched to the color of the emotion (most likely red) will help the young child understand graduations in intensity.

Some children enjoy working with magic markers, colored pencils or paint and can use color, size, and shape to express their angry feelings. Children can be encouraged to freely verbalize their anger or narrate a story while drawing. The consistent message to children is that the experience of emotion is valid, usual, and okay, but it's expression must occur in ways that do not hurt the self, others, or property. In this fashion an important distinction between anger as a feeling and aggression as a behavior is made. Crenshaw and Mordock (2005) suggest the drawing

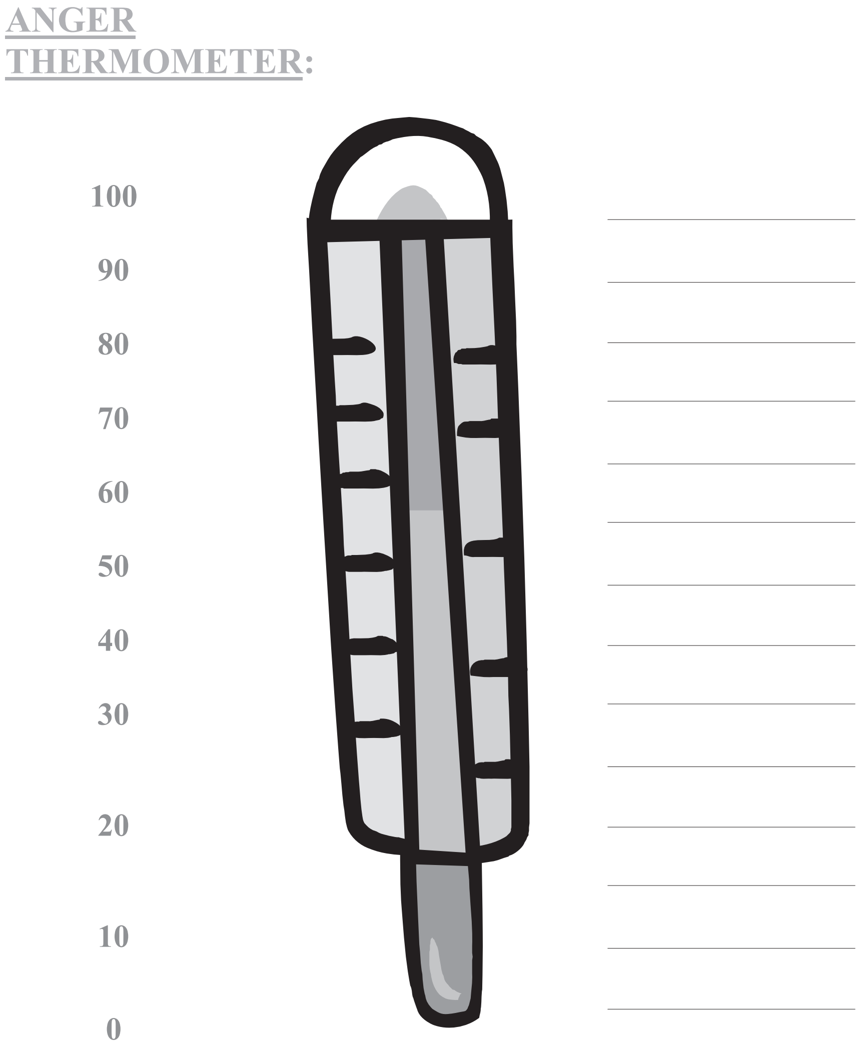

Figure 19.7 Anger Thermometer

of things that might symbolize a child's experiences of anger and that might be used as a metaphor for interpretation during the play therapy session. They suggest erupting volcanoes, storm pictures, and fire-breathing dragons and provide some examples in their comprehensive book.

SUMMARY AND RECOMMENDATIONS

Clearly there are many well-developed programs for helping young children develop the emotional competencies needed for healthy social functioning. Young children evidencing specific difficulties in the regulation of frustration and anger and those exhibiting aggressive behavior problems in their preschool years can benefit from a program.

Any comprehensive anger management program for young children would need to be multifaceted and target (a) the behavioral and cognitive skills needed to regulate the emotion of anger, (b) appropriate emotional expression, and (c) problem-solving skills for solving interpersonal conflict and managing frustration. In theory, given the contextual variables, both aggressive children and their parents should receive interventions as their daily interactions can provide the in vivo rehearsal of newly learned skills.

There are many intervention strategies that can be incorporated in programs for young children that will meet these treatment objectives. The use of various play strategies, bibliotherapy, puppet play, games, and drawing activities will engage young children and enhance their learning. Further, such strategies will help newly learned arousal management skills generalize across natural environments and will be better adapted to interactions with both peers and adults in those settings. Finally, parents and teachers play a crucial role in the implementation and maintenance of any therapeutic program for young children.

A note of caution, however, is necessary since the available research on the effects of these programs is extremely limited. Currently there are no published reports on the impact of anger management programs for young children and their families. What is needed are some program evaluations with comprehensive pre- and posttherapy assessments of children's anger and aggression, parents anger and aggression, and of interactions between parents and their children. Ideally, the usual paper-pencil inventories used in program evaluation would be supplemented by some kind of observations on actual behaviors of parents and children during frustrating situations. Anger management components of large-scale emotion competence training programs need to be examined as a distinct component as well as be considered in a varying sequence position. Finally, although many creative play therapists develop intervention strategies anchored in the child's developmental level, a comparison of intervention strategies in terms of treatment effectiveness seems necessary as well. We still need to understand what works best for which type of child and in what format so that anger management approaches can be optimally effective for young children.

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CHAPTER 20

Narrative Approaches: Helping Children Tell Their Stories

ANN CATTANACH

Story while Pointing at a Constellation.

A Dogrib Conversation.
Dogrib Indian. Canada.
''Somebody's chasing it''
''Hey- no''
''It's true''
''Which?''
''That one There. I'm pointing at it. Get behind me. Look past my hand,''
''Let me see,''
''See it?''
''Yes, who's chasing it?''
''Somebody always is. It's called The-One-Always-Chased,''
''Who's chasing it now?''
''Some other one,''
''Who?''
''The One-Who-Chases.''
''One time I was out walking. Out at night. I heard a loud flint scrape.''
''Flint-scrape?''
''Yes and I looked up to the sky.''
''The sound travelled down to you?''
''Yes, a flint scrape.''
''It was him. The One-Who-Chases. It wasn't the other one.''

''The other one wouldn't stop to make a fire like that.
He'd be found out.''

This is one of my favorite folk narratives because it so clearly defines two people co-constructing together to make a story which defines their culture and their relationship with each other. It is a playful exchange of ideas, and for me it defines the therapeutic relationship I hope to achieve as a narrative therapist helping children tell their stories. The key to a narrative approach is the way therapist and child co-construct together. This is the method of communication used to explore the child's narratives.

Children learn this skill through social play including the rhymes and stories hopefully told to them by parents, caregivers or teachers, and other children as a part of childhood play. It starts with peek-a-boo play common in all cultures and continues with playground rhymes, skipping games, clapping games, and the like. Dunn (1993) states that babies play an active part in interactional games like peek-a-boo and later hide-and-seek, enjoying the give-and-take of the play. She defines this play as two or more individuals working toward a mutual goal, with alternation of turns and repetition of actions.

The following rhyme is a typical question-and-answer play of give-and-take with the usual cultural references that localize the play.

What's in there?
Gold and money
Where's my share of it?
The mouse ran away with it
Where's the mousie?
In her housie
Where's her housie?
In the wood
The fire burnt it
Where's the fire?
The water quenched it
Where's the water?
The brown bull drank it
Where's the brown bull?
The back of Burnie Hill
Where's Burnie Hill?
All clad with snow
Where's the snow?
The sun melted it

Where's the sun?
High high up in the air.

Hopefully children will continue to play together despite the seductions of the computer age.

In Narrative Play Therapy therapist and child use these question-and-answer interactions that children have learnt from a very early age. The following dialogue was a discussion about a picture drawn by a nine-year-old boy.

Becoming Nothing
This is a don't know person.
Is it a boy?
Don't know. He is happy.
Why is he happy?
Don't know.
If you don't know I suppose you are always happy.
Don't know.
He is red and blue with white skin.
He doesn't know whether he likes that.
He is also gold and silver and green.
People think he is an idiot.
Is he because he keeps on saying 'Don't know'?
Don't know.
He has a Nike shirt
He has yellow trousers.
The shirt is gold and silver and red and blue.
He is a clown a don't know clown

NARRATIVE THERAPY IN PLAY THERAPY

Michael Frayn (2006) states that our mental life is interpretive all the time: We make our thoughts by having them, and mold our feelings by the way we feel them.

Engel (1995) states that every story a child tells contributes to a self-portrait, which he can look at, refer to, think about, and change, and this portrait can be used by others to develop an understanding of the storyteller. The stories we tell, whether they are about real or imagined events, convey our experience, our ideas, and a dimension of who we are.

When children come to play therapy they usually have a story to tell about themselves and what has happened to them. ''What am I,'' ''Perhaps

I am not,'' and ''It's my fault'' are constant themes. The stories are often overwhelmingly negative with the children taking the blame for their life circumstances. Alan was seven and trying to adjust to living with his adoptive parents. It was a struggle to adapt, and he found school difficult. When I asked him to tell me about himself he said that he was a naughty boy and had naughty behavior. He said he was talking all the time, wriggling, shouting, not doing his work at school, fighting the children, and not listening to the teacher. His story was negative, and he couldn't think of anything to say about himself that was a positive statement. He thought he was naughty, and sometimes in the dark at night he felt especially vulnerable as he tried not to wet the bed and ''Perhaps I am not'' was his overriding fear. He thought he disappeared in the dark. Jake, another seven-year-old found it hard to make friends at school. He always introduced himself by saying, ''Don't play with me, I'm bad. My mummy killed my sister.'' This history defined his identity. It was so overwhelming that he was unable to discover any other aspect of himself and felt obliged to tell everyone he met that he came from a terrible family.

The dominant stories these children presented were not helping them at school or at home as they continually sought through their behavior and talk to have their own opinions of themselves reinforced by those around them. They constantly set up situations to prove the dominant story that they were naughty or bad. In play therapy the themes the children presented in their social world also appeared in the imaginative stories they expressed. In therapy we played together with these stories, expanding themes, changing and shifting meanings, exploring alternative plots and solutions until the stories developed and new ways of being emerged. Alan's stories moved from themes of the child abandoned to the child adventuring and eventually going home to waiting parents. There were many twists and turns, but the theme of the child coping alone shifted, and as his stories developed some of the responsibilities of caring for the child were managed by adults taking on parenting roles. He explored what it meant to be a child in his new family and what he could expect from his new parents. His dominant story changed and he no longer presented himself as just a naughty boy.

Jake also told stories of abandoned children, lost in the world, lacking love and care, and taking responsibility for the actions of adults. As his play developed he learned to tolerate his feelings of grief, and after one session he asked me if I could find out what had happened to his sister because he wasn't really sure about the details of her death. We were then able to investigate the life and death of his sister and understand the circumstances of his early life so that the burden of responsibility for his sister's death was lifted from him. He could then begin to explore his present situation and describe himself as part of a loving family. He shifted the dominant story, which had limited his sense of self-worth and given him a narrow focus in which to explore his social world.

Narrative therapy can be used in play therapy as a way of helping children express and explore their experiences of life. The stories we tell, whether they are about real or imagined events, convey our experience, our ideas, and a dimension of who we are.

The therapist and child construct a space and a relationship together where the child can develop a personal and social identity by finding stories to tell about the self and the lived world of that self. The partnership agreement between child and therapist gives meaning to the play as it happens. The stories created in this playing space may not be true but often will be genuine and powerfully felt and expressed.

SOCIAL CONSTRUCTIONIST STANCE

This way of working uses themes developed in social construction theory. Burr and Butt (2000) state that postmodern thought proposes that we will never be able to penetrate the real with our imperfect perceptions and constructions. But we are naturally sense-making beings who interpret events and confer meanings upon things. They posit an objective world that is revealed to us through our senses. There is a split between the objective world and our subjective reality, and the world we experience is between subject and object. What we experience is both made and found. So we are limited both by events in the world and by our constructions of those events. We might describe this as the lived world. The perceived world is not a more or less perfect replica of objective reality: We produce constructions that serve our purposes and help us in our projects.

HERMENEUTIC APPROACH

This social constructionist view of the world is a hermeneutic approach. Hermeneutics is the activity of interpreting and explores how meaning is constructed through language discourse, story, and narrative. In this form of analysis the world appears as we interpret it, and the search for meaning is ongoing. Knowledge is a socially interpreted event constructed through the relationship and conversation with others. Anderson and Goolishian (1992) state that a therapist working in a hermeneutic way lets the person's story unfold until a coherent theme or new meaning emerges from the dialogue. It is the therapist's curiosity to know more about what is being said, that is, how a client makes meaning that engages the future or not-yet-said narrative. Therapeutic conversation involves a mutual search for understanding in which the therapist and client talk *with* not *to* each other. This not-knowing hermeneutic stance is the therapist's expertise to support the child in finding their own meaning in understanding their own problem.

The basis of narrative therapy when used in play therapy is to explore the stories children present in play and facilitate an exchange of ideas and thoughts about the stories. This approach means that the relationship between child and therapist is one of co-construction, sharing ideas and listening to each other to find the story which best supports the child in what they want to say. This is a hermeneutic stance because the therapist's listening response is a continuous inquiry toward the material presented in a play session. This developing narrative always presents the therapist with the next question. This is a *not knowing* position; the therapist's understanding is always developing.

THE NARRATIVE FOCUS

White (2005) lists a series of concepts which describe his key ideas of narrative therapy. He states that the primary focus of a narrative approach is people's expressions of their experiences of life. The narrative expressions of both adults and children act as interpretations, and through these interpretations people give meaning to their experiences of life, which seem sensible to themselves and to others. He states that meaning does not preexist the interpretation of experience.

He considers that expressions are constitutive of life, the world that is lived through; they structure experience and inform future understanding. Expressions have a cultural context and are informed by the knowledge and practices of life that are culturally determined. The structure of narrative provides the principle frame of intelligibility for people in their day-to-day lives. It is through this frame that people link together the events of life in sequences that unfold through time according to specific themes.

A narrative therapy is about options for the telling and retelling of the preferred stories of people's lives—rendering the unique, the contradictory, the contingent, and at times the aberrant events of people's lives significant as alternative presents. White and Epston (1990) make the assumption that individuals experience problems when the narratives in which they are storying their experience and/or in which they are having their experience storied by others do not sufficiently represent their lived experience and that in these circumstances there will be significant aspects of their lived experience that contradict these dominant narratives.

PRETEND PLAY: THE LANDSCAPE OF THE IMAGINATION

Children develop their narratives and stories through pretend play, and it is through entering this world that adult and child can develop a relationship that helps both participants in their understanding of their relationship, the world, and their place in it. Pretend play requires the ability to transform objects and actions symbolically; it is developed through social dialogue and involves play with objects, role taking, and improvisation.

Vygotsky (1978) states that the criteria for distinguishing a child's play from other forms of activity is that in play a child creates an imaginary situation. He states that a child's creation of an imaginary situation is the first manifestation of the child's emancipation from situational constraints. The paradox of play is that the child operates with an alienated meaning in a real situation.

> So I was playing with Macy in her foster home.
> Macy made a sofa out of Play-Doh. It had pink and blue pillows.
> I asked her who is going to sit on the sofa.
> ''Nobody it is just there,'' said Macy.
> ''There is a white snowman like a cushion on the sofa.
> Not a real snowman it would just melt. It is a teddy snowman.
> The baby is sitting between two baby snowmen.
> They look after the baby.''
> I ask if the baby has a mum.
> Macy replies:
> ''Her old mum is dead but she has a new mum.''
> I ask if the mum has a name.
> Macy says:
> ''Mum has no name.
> The baby just calls her mum.
> The baby's name is Tom Tom.''

In reality Macy is waiting for a new family and has been in care for over two years. In play she is emancipated from that situation so she structures her story in a way which makes sense. Macy enjoys the experience and likes my questions that help her develop her play story to her own satisfaction.

Vygotsky (1978) states that there is great pleasure for the child in the act of playing an imaginary story, but in order to achieve the greatest pleasure and satisfaction the child must learn and keep the rules. So Macy and I have rules about playing together, and as she structures her play and stories she is learning the rules of sequencing and coherence to make a story which satisfies her. In play, action is subordinated to meaning, but in real life action dominates meaning. In her reality world, when Macy visits her birth family the environment is chaotic and she gets lost in the crowd. In her play world, adults seem to be represented as snowmen who disappear and melt so are little comfort for the baby. Although the baby has a mum, she is invisible, not yet realized, which is a reflection of her reality world. In her play the baby and teddy are the only solid characters, all the others are prone to disappear.

Children tell stories not only to represent experience as they know it to be, but they also tell stories to represent experience as they would like it to be. The imaginative control you gain over the world by being able to decide at least symbolically who does what to whom and what things look like and sound like is itself a vital component of human experience.

Petra is 14 years old living in a small and loving children's home where she feels safe and contained. She has serious attachment issues with her birth family. She drew a heart and told this story:

> There was once a heart which belonged to no one.
> No one loved it and it floated in space like a loner.
> This heart had never belonged to anyone neither male nor female
> And it was broken.
> It had an arrow piercing the flesh, no blood, just a purple heart.
> And in the end it was exploded by an Iraqi bomb
> And spattered into a thousand and one pieces.
> It might possibly be put together again.
> But if it falls into another person it will be born again
> And the person with the purple heart
> Will be happy and live forever.
> The End.

This tentative expression of hope can be contained within a story, which is the safe place to express such desires because it does not have to be proved in the lived world.

There are many terms for pretend play such as symbolic, make-believe, dramatic, or fantasy play. All these terms define a specific process distinguished from other forms of play (practice, sensorimotor, functional, games with rules) by the criteria of nonliteral play. It is the ''as if'' function of pretend play that distinguishes its quality. Children engage in pretend play when they give identities and functions to objects and people that they do not possess in reality. These identities and functions then transform and transcend reality.

Pretend play usually begins in the second half of the second year when children start to do simple actions like pretending to eat with toy spoons and pouring out pretend drinks. The precursor for this kind of play is the parent/caregiver-child interactions when the child is about one year old. The adult signals to the child through exaggeration, increased gazing and smiling at the child that they are not acting seriously but pretending. Children who have not yet learned to pretend themselves still show sensitivity to the adults' pretence actions. They gaze and smile more toward the adult when she pretends than when she does a proper serious action (Richert et al., 2002). Children up to four years of age will often use a body part as substitutes for objects in pretend play. For example when pretending to brush their teeth they will use the index finger to represent the toothbrush. Four year olds will mime the toothbrush, and as children develop they can develop structured sequences in their play and storytelling.

Novosyolova (1991) developed a scheme of the forms of action occurring during the development of play. This scheme describes four forms of action. In the first year of life there is *familiarizing play*, which includes exploring the toy, actions with the toy, and actions with the toy as a tool. In the second and third years of life *imaginative play* and *thematic imaginative play* develops. The content of this play is drawn from the child's life experience, and the play is about everyday situations. Playful actions are often repeated. So the child puts a doll to bed, covers it with a blanket, then takes it out of the bed, puts it back in the bed and so on. This play can use toys, replacement objects, *as if* actions and actions with imaginary objects. From three to seven years *thematic role-play* emerges. There is an emotional expression of role through the use of the toy, so for example the child plays mother by putting the doll to bed and talking to the doll, connecting speech with the role taken. There is often role-discussion with other children who are playing. Novosyolova states that children combine individual events from everyday life with imaginary situations. These may sometimes even take on a fairy tale character, yet they are always based on children's own personal experience.

Brian, age five, made the following story with small toys and slime.

The Damp Place

The damp place was a bad place but it has now turned good because Brian wanted it good.

In the pond is a ball that wasn't well and all the creatures in the pond wasn't well.
This was an alien and he wasn't well and a dinosaur.
The pond made them ill because it had bad poison and germs in it.
It is not scary but people get ill because it is dirty.
The pond got full with hundreds and hundreds of creatures.
And in the end they all died so the pond was empty.
The End.

He is using the toys to create an imaginary story, and elements of the story define the way he represents his world at that particular time when he was playing with me. It is important to remember that children use pretend play to experiment with their ideas about the worst things and the best things in their world as well as the worst people and the best people. They do not necessarily wish to carry these stories into their lived world, but they perhaps find comfort in experimenting with ideas in the presence of a supportive adult who can keep them safe enough to think the unthinkable.

An example is a story by Ted, age five, who was to move to a permanent family after some time in care. He told everyone how happy he was to move and had no fears at all. His story in play expressed his excitement but also his anxieties.

Ted was looking for a new mum and dad.
He was in a police car.
Another car came along with Ted's new mum and dad
They saw Ted in the police car and called out to him.
And he was so pleased to get a new mum and dad.
Somebody took Ted away because they didn't want him to have a new mum and dad.
They took Ted to jail.
Ted was crying.
The door shuts and Ted is trapped in the jail.
The fire engine came to rescue Ted.
The police were sorry and said
"You go back to your new mum and dad."
Ted is flying in the fire engine.
"Hello I'm lost," say Ted.
"The fire burnt down my new mum's home."
Ted is inside the house on the roof and he falls off.
But doesn't get hurt.
The fire was put out and Ted went down.

All the cars went away
And that's the end of the story.

This is a pretend story but it shows a hero who is not certain about adults and whether they will care for him. Are they strong enough to combat external events, and will Ted ever get to find them in the first place? At the end of the story it is not clear if the hero's new mum and dad will be able to care for him. He survives the fire, the cars go away, and that is as much as Ted can imagine at this moment. This was Ted's symbolic experiment with imaginative choices in his playing world, distanced from the consequences of those choices in his reality world. So we stay with the story as it is. Ted was able to describe his anxieties in his play and stories but not in general conversation with his caregivers or social worker. To them he appeared to be coping well with the move to a new family so it was helpful to discuss Ted's anxieties with his present caregivers and new family so they were aware of his fears.

When children play imaginatively in whatever context, they create a fictional world that can be a way of making sense of their lived life. Vandenberg (1986) states that to be human and live in a meaningful way within a culture requires that we live in and through a very sophisticated abstract system that is largely imaginary. Our social relationships and our understanding of our work and our culture depend on our understanding of these systems of communication, both verbal and nonverbal. Jokes, irony, skills of persuasion, figures of speech are all part of this system as well as nonverbal signals and signs like eye contact, smiling.

PRETEND PLAY AS NARRATIVE

Telling stories as a means of constructing social meaning is embedded in all human cultures and traditions, and it may well be a biological given. (Bruner, 1990). Once children have begun to acquire language they show an ability to organize their experience in a narrative form. It is through these narratives that children express their unique way of thinking and feeling about themselves, their own personal voice, and what it is like to be in their world. So Ted's world when he told me his story was one that contained his wishes and fears and expressed the unknown future with all his desires, longings, and terrors. Play is the natural way for children to construct coherence and meaning, which is the purpose of narrative. From a narrative perspective the invitation to play is no more than the posing of the autobiographical request to ''tell me your story.''

Engel (1995) states that it is also important to recognize that stories not only reconstruct experience and communicate experience but they *are* experience, and through the stories we tell, especially the stories we tell about ourselves, we construct ourselves. At any given moment how we behave, feel, and experience ourselves grows in part out of the self we have woven together from all our past experiences and imaginings about the future.

ADULT AND CHILD PLAYING TOGETHER

There is a very special quality to a relationship based on storytelling. There is a storyteller and a listener, and the story acts in the middle as a way to negotiate a shared meaning between the two. I have stated elsewhere (1997) that in play therapy children tell stories as containers for their experiences, constructed into the fictional narrative of a story. There is a playfulness in the communication, whatever the horror of the story, and the roles of storyteller and listener both have an equal function as the story emerges in the space between the two. There has to be a spark of recognition between storyteller and listener as the story unfolds. The equality in the relationship facilitates the unfolding of the story. Together the adult and child share the drama of the story as the meaning emerges. The not knowing-knowing adult does not displace this process with a hierarchy of adult knowledge but learns to listen in a way that supports the unfolding of the tale. The story can be acknowledged by the adult who as listener values what is presented. Or the child and adult can deconstruct and then reconstruct the story to the satisfaction of the child if new options seem desirable. This is defined as a polyvocal collaboration. The aim is not to locate a solution or a new story but to generate a range of new options.

Mary, age four, likes to play with a witch doll. The doll is the bad witch. At the end of the story Mary thought of many endings. So the bad witch can be dead never to come alive again, be dead but come alive, go to prison, change into a good witch. She didn't have to make a choice just to tell me what might happen. There were options.

Goolishian (1990) describes the relationship between therapist and child. He states that to maintain a position of openness and uncertainty in a therapeutic conversation requires the skill and patience of an experienced therapist. The therapist's not knowing does not mean the dissolutionment or abandonment of prior knowledge but rather it's questioning. Not knowing refers to what I do with what I know. This equally applies to the parent/caregiver of the child or professional worker forging a relationship. The knowledge base for parent/caregiver, professional worker, and therapist will be different, but all have a value for the child if the adult can critically evaluate their knowledge base and define what can support the development of the child as they play together.

From my perspective as a play therapist my knowledge base comes from a variety of sources: theory, training, clinical and life experiences, knowledge of empirical research, intuition, empathy, shared knowledge with other colleagues. This knowledge base has to be used hermeneutically so that it enriches the client's understanding rather than closing it off by imposing an expert opinion. So knowledge is brought to the therapeutic conversation as part of the desire to understand more. The knowledge base of the parent/caregiver or other professional workers is equally valid. It is helpful if the adult is aware and can define their skills that would support the relationship between child and adult and continually monitor the relationship to ensure that the needs of the child are paramount.

PLAY AS A CULTURAL ROUTINE

The way the adult negotiates playing with the child is crucial to the coworking of the interaction. If the structure is clear, the play becomes another cultural routine, which gives the child a sense of belonging, a place where the child has a role and responsibilities. Corsaro (1997) describes a cultural routine as a place where the child has the security and shared understanding of belonging to a social group. Because the routine is predictable this provides a framework within which a wide range of sociocultural knowledge can be produced, displayed, and interpreted. These routines serve as anchors, which enable the child to deal with ambiguities, the unexpected, and the problematic while remaining within the confines of everyday life.

Participation in cultural routines begins early with, for example, simple participation in the game of peek-a-boo. Initially the child learns a set of predictable rules, which make up the game, then they learn that embellishment of the rules is possible as the play routine develops. Initially in these routines, the games often proceed on an ''as if'' assumption, which means that the adult assumes that the child is capable of social interaction until the child gradually learns to be socially competent and can fully participate in these social routines.

If we explore our pretend play together as a cultural routine, then the structure of the play must be well described to the child. The rules and boundaries are vital to the safety of the relationship and must clarify the roles and responsibility for both adult and child. The child needs to feel safe with the adult, but must also feel confident that the adult can enter his play world and help make sense of the confusion and misunderstandings that might be creating difficulties for the child. In this way the adult together with the child mediate some satisfactory meaning that is congruent with the child's social world. As the routines of pretend play are learned and experienced, then the child expands the meanings of the play and stories and learns more complex social communication.

The mediating materials are the play, story-making with toys and objects, and stories the therapist tells or reads that extends the child's individual experience to a cultural generality. The cultural routines are also established and reinforced through the narratives spoken between the adult and child during their time together. Children enjoy their mastery over the space, structure, and the time spent with the adult, and they are very strict that all the routine is maintained. It is often while setting up the area for play that the child will tell an imaginary story or narrate a family or school situation.

THE PLAYING SPACE

When children engage in pretend play they find a place where they feel safe enough to play. Children play in spaces on the borders of everyday life—perhaps under the table, down in the den, at the bottom of the garden, in their bedroom—but in spaces where they can still keep contact with their family or social group. I still fondly remember my little attic room where I played school and especially the lock on the door so I could keep my bossy sister out.

Bateson (1955) states that before engaging in imaginative play children must establish a play ''frame'' or context to let others know that what is happening is play, that it is not real. This is usually done by smiling and laughing. In pretend play children operate on two levels. At one level they are involved in their pretend roles and focus on the make-believe meaning of objects and actions. At the same time they are aware of their own identities, the other players' identities, and the real-life meaning of the objects and actions used in the play.

In everyday life autistic children hardly engage in spontaneous pretend play, but studies (Lewis & Boucher, 1988; Libby, Powell, Messer, & Jordan, 1997) found that autistic children were able to use pretend play when it was scaffolded and elicited through modeling and instruction to imitate in highly supportive social contexts. I remember working in the Netherlands with a group of autistic adolescents who were able to play scenes of café life once the structure had been modeled for them. They could not spontaneously develop the narrative but enjoyed playing people in a café drinking coffee. They took great comfort each week from the repetition of the scene, which created a cultural routine for the group with each individual clear about their role in the scene.

As a play therapist, if I am meeting children in their home environment, we choose a place to play that does not interrupt the flow of activity in the home, perhaps the child's bedroom or dining room. There is nothing worse than depriving the rest of the household from their routine activities by taking the central room in the house. Parents or caregivers could find a special place and time in the house for pretend play and make it part of family life for the child or children. This can support attachment between adult and child, giving the child affirmation that what they play is interesting for the adult.

If professional workers are using rooms or a playroom away from the home environment, it is important that the space is nurturing for the child. I always use a special blue mat to sit on with the child and this delineates the playing area. The mat is large enough to seat the child, myself, and the toys. It is important in each environment to have a playing place and a non-playing space in the same room so the child can stop playing without leaving the room. This gives clarity about when the child is playing and when the play is over or stopped for a while.

RULES WHEN PLAYING TOGETHER

It is important to have rules when adult and child play together. The rules are about whom is responsible for what. The adult will bring the toys and will be responsible for bringing the same toys each time and keeping them safe meanwhile. Parents/caregivers may want to select some special toys and objects for this special time of play with the child, and these can be kept separate from the general toys in the household and in a special place. Many children want to set out the place and the space because it is perhaps one environment over which they can gain mastery. Most of the children I see want to put the mat out and organize our sitting together. Play is the child's world and one of the few places where they have control over the setting and can choose the play objects and set the scene.

The child is expected to play and make stories. That is their responsibility. The adult is expected to listen to the child and also participate in the play at the request of the child. The adult is responsible for bringing the toys and other play materials and for making sure the same toys are available for each play session. Professional workers may want to have their own set of toys because general toys kept in a playroom can get lost and broken and do not hold the same value for the child as toys which are special for the playing adult.

Both child and adult are responsible for rules of behavior: no hitting and hurting, respect for body boundaries, respect for each other. The structure is very important for the child so they know what is expected, and feeling safe they can develop their play in the space, through time, with toys and objects.

TOYS FOR PRETEND PLAY

The choice of toys to encourage children to play together with an adult is largely determined by the preferences of the players and the environment where the play takes place. If the adult is taking toys to the child, then the selection has to be limited but should include materials for sensory play, figures for story making, and art materials. If the meetings are in a playroom or at home, then the choices are less limited. However, some children can be overwhelmed by too much stimulation, so too many toys can be unhelpful. A small box of interesting toys is as valuable as a playroom full of objects randomly selected. The play between child and adult is special so the same toys should always be there at each playtime. There is nothing worse for a child than to find a key toy is missing or broken so one of the rules should be for the adult to keep the toys safe.

The following are suggestions for playing materials.

SENSORY MATERIALS

Slime, Play-Doh, clay, sand, bubbles are a stimulus for sensory play. Children often start their pretend play with sensory play. It seems to focus children into the playing mode. Sometimes the sensory materials become part of a pretend story, so figures are placed in slime or sand or Play-Doh and the materials are often used as a metaphor for the messiness in the children's lives. John, age four, made a pond with pink slime, placed small figures in the slime, and told the following story:

> Once upon a time there was a pond.
> It was a scary place.
> The people were scary and the pond.
> The pond was very cold.
> There was an alien in the pond
> But it was dead.
> A foot was in the pond and it was all messy.
> A lizard came there and a dinosaur
> And they all had a swim.

John had just moved to an adoptive family and perhaps his story expressed what that might be like for him trying to cope with new people, a new place, and new rules.

SMALL FIGURES

A selection of small figures facilitate story making and might include:

A group of family figures: If children have lived in several families there should be enough figures to represent this. ''The Simpsons'' family is often used by children in family stories.
Include ethnic figures.

Magical figures: Include dragons and witches, knights, and current figures from film and television. I note that ninja turtles are back in favor so I can retrieve them from storage.

Animals—Wild and domestic: Lions, tigers, elephants, foxes, hares, penguins and so forth. Dogs, cats, other domestic animals, rabbits, farm animals, and donkeys are popular.

Cars and things: Cars are very important objects denoting for many children a safe place to be. Also cars move from place to place. Unattached children often make stories with cars being driven with no drivers, no people around. This is often repetitive play before the child learns to develop a story. Planes, helicopters, skateboards all denote movement.

The environment: Small objects to denote surroundings outdoors (trees, a bench, signs, etc.) and indoors (a bed, a chair, sofa, a potty, etc.).

This is a story from Stuart, age seven, using small figures:

The Witch Murders
There was a witch called Madge,
And she bites people.
She bit Bart Simpson's dad
And killed him and ate him up.
She buried him in sand.
Then Madge ate a man
Then a cow then a bat then a dog
Then a metal dog then a snake
Then a fish then a sheep
Then Bart Simpson then a huge snake
Then a girl then a big snake and a caterpillar.

Then a knight killed her to death
And brought all the people back alive.

Dolls and puppets: Dolls with clothes and feeding bottles, and so on. Hand puppets that are easy to manipulate. Animal puppets can include crocodiles, wolves, and dogs. Include fierce creatures and warm and loving figures.

Dressing-up clothes: These can include adult clothes as well as specific costumes (like Spiderman, etc.) Also shoes, bags, hats, and lots of interesting material to make cloaks, and so on.

Materials for Drawing and Painting: Paint, a variety of crayons and pastels, colored paper, and tactile paper masks to draw on.

THE ADULT AS STORYTELLER

When I listen to the stories children make up in play I am often reminded of folk tales or stories which are congruent with what the child has invented. I then might tell the story to the child, because to know that other people have told stories with similar themes can help the child feel like everybody else rather than the only person in the world who has their life experiences or who can tell such stories.

I see two boys who are nine years old and they are at the stage of telling gruesome stories and trying out shock tactics. They have been in trouble for swearing at the wrong people in the wrong places. We explore these issues as they play, and they make up gruesome stories to shock themselves and me. I told them the story of the boy on the ice. They were impressed and asked if the story was true. ''Who knows,'' I said. ''it's a story.'' We all laughed; there were others out there who had our sense of the gruesome.

> Keep a Cool Head
>
> He was a great lad for telling stories, he had a great lot of stories, and there was a New Year's Day, ice came on the loch, and all the young boys came down there skating.
>
> They were all out there, ice on the loch, and they were skating and then one of the boys got a bit too far out, and in the middle of the loch the ice was soft, and it broke with him and he went down, down in a hole, and the other edge of the ice just caught him under the chin.
>
> He slid away under the ice till he came to another hole, and his head did the same on top of the ice, and when they came together there his head just stuck on again . . . the frost was that strong it just froze his head on again.

> In the evening then they were sitting around the hearth telling stories, and the boy was there too, and he was getting rid of some of the cold with his dip in the cold water, you know, and he starts to sneeze.
>
> As he was going to blow his nose, they just blow their nose with their fingers then you know, as he was going to blow his nose and with the heat, it kind of thawed the ice about his neck, you knows, he aimed his head and it shot right into the fire.

Sarah, age six, liked to end her play with a funny story and always the same story because this was a predictable moment in a turbulent life. It is a funny, silly story and made us laugh about speaking before thinking of consequences. Sarah liked to join in when each wish was gone so now we tell the story together.

The Three Wishes
A little man came to a wee house on a wet day and asked for supper.
They gave him a bowl of soup and some bread
And when he went they gave him a little round thing
And said it would give him three wishes.
So the next morning the man said,
''Soup again, I wish I had a pudding for a change.''
And there was a pudding.
''Oh you fool,'' said his wife,
''One wish gone, I wish the pudding was on your head!''
And it was.
''That's two wishes gone,'' said the man.
The wife said, ''You ought to have wished for a gold bar or anything.''
''I wish the pudding was off my head,'' said the man.
And that was the three wishes gone.

THE IMPORTANCE OF PRETEND PLAY AND COGNITIVE COMPETENCE

There is a narrative about children's play that defines it as trivial, unimportant, and that the child should grow up and leave such nonsense behind. However, as research into pretend play evolves, it is clear that pretend play is key to the cognitive competence of the child.

Bergen (2002) states that there is a growing body of evidence supporting the many connections between cognitive competence and high-quality pretend play. If children lack opportunities to experience such play, their long-term capacities related to metacognition, problem solving, and social cognition, as well as to academic areas such as literacy, mathematics, and science, may be diminished. These complex and multidimensional skills involving many areas of the brain are most likely to thrive in an atmosphere rich in high-quality pretend play.

WORKING WITH KATIE, WHO WAS ANGRY

Bowlby (1969–1980) states that the particular pathways the child proceeds along are determined by the environment he meets with, especially the way his parents (or parent substitutes) treat him and how he responds to them. For some children experiencing repeated angry responses from their caregivers can give the child a license to behave in similar ways. Some caregivers actively encourage their children to respond aggressively in their relationships with others. Other children who have not been given help to regulate their emotions are often overwhelmed by their anger and have no means to calm themselves.

Katie, age seven, explained her confusion living with a new family.

I don't understand the rules
I don't like shouting.
Even though I get mad
And shout a lot too.
Old dad shouts too much.

Then she drew a picture and told the following story:

This is daddy's boot.
He wears it to work.
He kicks people with it.
He kicks Big John.
It hurts when he kicks
And he goes 'Boo, hoo.'
The boot is in the house.
It is a nice house.
They are having words in the house.
Big John is crying
Because he has been kicked.
There are lots of tears.
There is another boot.
It is Big John's boot.

It is a kicking boot.
This is a picture of the dark.
Big John in the dark gets scared.
He is scared in the dark.
Little John hates him.

This narrative clearly describes how violence is mirrored from adult to child if it is the only form of communication in the family. Big John can only defend himself by getting a kicking boot like daddy. He holds his boot in the dark, afraid of the dark, fearful of another kicking from daddy. He can only defend himself with his own kicking boot. Violence is this family's only form of communication.

Katie and I used play around body awareness and sensory awareness so she could become tuned into her body states. When she had been a witness to anger and violence in her early years, she had stayed frozen to stay safe.

We used some breathing exercises for relaxation, for example:

Forced Air
Suck in air.
Through tightly pursed lips
As though sucking on a straw.
Push out the air
As though squeezing water from a sponge.
Think of the places where your body feels tense.

Once Katie became aware of her body states she liked to draw herself and track feelings in her body.

Drawing Me When Angry
We can draw ourselves
and color in the places on our body where we feel anger.
What colors can we use to represent anger?
Is it the face, teeth grinding, forehead wrinkled?
Or the arms and fists.
Or the stomach all churning up.
Or the legs.
Knees tense, feet ready to kick
So how does this affect us?
Can we think sensibly when the body is in this state?
What is the difference between being a little bit angry?
And a big bit angry.

Drawing Me When Calm
We can draw ourselves
And color in the places on our body where we feel calm.
What is the difference in the body between angry feelings and calm feelings?
What is good about both states?
What is not good about both states?

We talked together about what made her angry and explored the different degrees of anger from mild irritation to extreme anger. She found her own words to express these differences.

I told her the following story about nonviolence when we were thinking about degrees of anger:

Nonviolence
Bengali
A very wicked snake infested a road and bit passers-by.
A holy man happened to pass that way, and the snake rushed at him to bite him.
He calmly looked down at him and said, ''You want to bite me, don't you. Go ahead.''
The snake was subdued by this unusual response and was overpowered by the gentleness of the holy man.
The holy man said, ''Listen, dear friend, how about promising me that you won't bite anyone from now on.''
The snake bowed and nodded agreement.
The holy man went on his way, and the snake began its life of innocence and nonviolence.
Very soon the neighborhood discovered that the snake was harmless, and the boys began to tease it mercilessly.
They pelted it with stone and dragged it around by its tail.
Still it kept its promise to the holy man and suffered.
Fortunately the holy man happened to come by and see his latest disciple.
He was touched by the bruised and battered condition of the snake.
When he asked it what happened the snake said feebly,
''Oh holy man, you said I should not bite anyone. But people are merciless.''
The holy man answered, ''I asked you not to bite anyone.
But I didn't ask you not to hiss.''

As Katie settled with her new family her angry explosions lessened. She had words to express grades of feeling, and her new family kept her safe through her angry episodes. Then she felt safe enough to explore aspects of her identity in play therapy through narratives where the dominant themes were less about angry people to stories about children playing and being helped by adults who cared for them. The angry themes returned in times of anxiety. It was still hard for Katie to trust adults, but she began to learn that there were many ways to show how she was feeling and get the nurture she so desired.

TWO STORIES FOR THERAPISTS

The urge to make it better sometimes makes it difficult for children to express sadness or anger for fear of upsetting the grown-ups. This ancient Chinese poem describes the consequences of life without joy and sadness.

After Lunch
Po Chu-I
After lunch-one short nap;
On waking up-two cups of tea.
Raising my head, I see the sun's light:
Once again slanting to the south-west.
Those who are happy regret the shortness of the day;
Those who are sad tire of the year's sloth.
But those whose hearts are devoid of joy and sadness
Just go on living, regardless of ''short'' or ''long.''

The most important quality for the therapist who co-constructs with a child is to be a sensitive listener. So think of the story of the hungry elephant.

The Story of the Hungry Elephant
West African
Once there lived an elephant, and he said to himself,
''I am hungry.'' He went along a path in the forest
  and came to a bamboo-palm standing in a swamp.
Roughly he tore down the palm,
He saw a tender bud in one of its leaves.
But as he took the bud from the leaf
It fell into the water.
He hunted and hunted yet could not find it
  because he had stirred up the water
  and it blinded his eyes.
Then a frog spoke and said,

''Listen.''
The elephant did not hear, thrashing the water
hard with his trunk.
The frog spoke again:
''Listen.''
The elephant heard this time, and stood perfectly still,
curious.
Thereupon the water became clear so that
he found the palm-bud and ate it.

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CHAPTER 21

Family Problem Solving: Using Expressive Activities

STEVE HARVEY

Nick, a nine-year-old boy, was referred to a mental health service by both his mother and his primary school for multiple problems. His school counselor reported that he was struggling academically, was defiant and oppositional to his teachers, had poor social skills and few friends, and was stealing from his peers and hording these items. He was also often bullied by other older boys and would harass others in retaliation. When he was confronted with his behaviors, he would sometimes leave school or begin crying. He was often inconsolable at school. His mother, Kay, reported that Nick was also very emotional and cried daily even when very small things happened. He often had nightmares and a strong fantasy life that included many monsters and devils that were after him. Though he was often anxious, he could also be considerate and loving toward his older sister and mother. When he was misbehaving, Nick was unable to control his behavior for several days.

Nick was living with Kay, her new partner, Ron, and his eleven-year-old sister, Brianna. His birth parents had divorced four years earlier after a volatile relationship that included extensive domestic violence. Brianna and Nick had witnessed these physical assaults. Kay reported that though she and Ron had a largely positive and committed relationship, Ron became very angry and frustrated with Nick's behavior to the point where she and Ron would argue often and had considered separating. Brianna often tried to discipline Nick, and this in turn led to physical conflict between these two siblings leaving them both feeling angry and alienated from what otherwise was a positive relationship. This conflict would spill over into the school they both attended, to the point that the school counselor and principal had become involved with Brianna as well due to her aggression toward peers.

Kay was desperate to help Nick and Brianna as she believed the stress was harming her and the family life she and Ron were trying to establish. Kay was working as an assistant manager of a clothing store, and Ron was a builder. Both were relatively low paid despite the demands of their jobs. This couple reported that they needed both incomes to meet their financial obligations. Appointments with the whole family together were hard to arrange due to these work commitments. Kay reported that she had tried "everything" to set limits for Nick and separate him from Brianna when the older sibling became too intrusive and upset with her brother. However nothing she attempted seemed to work. Ron reported that he had also tried to help Nick, though he could see that his more traditional discipline only led his stepson to become more emotionally upset, so he had left most of the limit setting to Kay.

Kay said that she had been trying to arrange for some kind of counseling for quite some time, but Nick and Brianna's father had refused to give his consent as he did not want "anyone to get inside his children's head." Kay had only recently received legal approval to seek treatment. Kay said that she was having emotional difficulty adjusting to this constant stress as it had been ongoing for several years.

The therapist arranged an intake with Brianna, Nick, and Kay initially with the understanding that Ron would become involved during the intervention on a less frequent basis to accommodate for his work demands. The first session included a joint verbal interview. As Kay began describing the problems she was having with her children, Nick started to cry, and Brianna became angry saying that she wanted to have her own therapist because Nick's problems were not hers. All the family members agreed that this arguing was like what happened at home and that they were not able to stop it. The room became filled with a distressed feeling quickly following these interactions. The family was split up at this point, as the therapist wanted to gain more information and the conflict was likely to continue. Nick completed several drawings including a drawing of his family. Brianna completed a similar drawing as well as some behavioral checklists to gain an idea of how she rated her problem levels. The therapist also talked with Kay about the children's history and made plans for further evaluation activities.

Kay reported that the children had a relatively normal medical and developmental background. Neither child had experienced psychological trauma, physical or sexual abuse, as far as she knew, and both children had positive relationships with her and would talk openly about most things at times. Brianna had always done well in school, though she could be controlling with her peers. Nick, on the other hand, had always had few friends, had trouble separating from her, and had constant learning problems. Kay reported that she had several male relatives who also had trouble learning and a cousin who had diagnosed attention difficulties. Nick was referred for a cognitive/educational assessment, which did identify learning problems. This was addressed through adjustments made in his individualized learning plan (IEP) at school. This plan helped Nick at school and continued throughout the time he was seen in family-oriented play therapy.

The therapist talked with Nick next about his family drawing. He drew his current family eating dinner together except for himself. He placed his figure in a more isolated position and made his body more colorful than the others. When asked about what was occurring, Nick told a story about a bird attacking his figure and as having lava shooting out of his brain in the picture. Nick was unable to connect these metaphors to his own experience when asked if he felt like what he had represented.

Brianna stated that her main problems had to do with controlling her anger and she wanted to develop ways to express herself more appropriately. While she agreed that she would need to spend some time working on how to cooperate with her brother, she wanted her own therapist to talk with her.

Before the family left, the therapist told Kay, Nick, and Brianna that their sessions would address their fighting with each other, Nick's sadness, Brianna's anger, and help them learn to cooperate more together. The sessions would include some play all together; some play sessions with Brianna and Nick, and some individual play and discussion with each child. Brianna would have her own therapist, and the current therapist would see Nick. When the family members met together, the two therapists would also both attend. Ron and Kay would be seen together as parents to help develop mutual plans and contain their stress related to parenting. The plan would be flexible such that individual, conjoint sibling play, and family play sessions would occur in stages depending on their needs and as the various goals were accomplished. The next week was set up to include an individual session with Brianna and her new therapist and a joint session with Kay and Nick in which they would play together using expression as a way to develop and improve emotional communication.

The following week, Kay and Nick were asked to complete a few structured interactive play activities together to get an idea of how their problems were expressed in their play process as well as in the metaphors they developed. The therapist was also able to use this interaction to gain an estimate of the relationship quality between Nick and his mother as well as an introduction to mutual play as an intervention technique to address their concerns. This use of interactive play evaluation and types of semistructured activities has been presented more completely in a previous work (Harvey, 2000).

In this initial play-oriented session, the therapist first asked Kay and Nick each to draw a house on a large piece of paper and add a series of roads and parts of a town (e.g., parks, swimming pool, restaurant). They were then asked to draw a story of themselves coming out of their house and visiting their town and finally to develop a story of their interactions together. After the drawing, Nick and Kay were asked to build a house with pillows and use various stuffed animals to develop a story about a family. As part of this story, Kay would leave Nick to continue the story on his own after she had played with him for several minutes.

During the drawing, Kay recognized Nick's ideas and added drawing and story elements to develop what he had started. Nick however kept finding ways to show his figure withdrawing or starting a conflict with his mother's figure. In the end, he showed his figure running off the page, leaving his mother not quite knowing what to do. During the dramatic play, Kay used the pillows to build a house in which Nick gathered the soft animals and brought them together. During most of the building activity, Kay and Nick were sharing positive feelings with each other. However, Nick introduced a story scene between some of the soft animals that Kay could not see. When she was asked to leave, Nick elaborated these scenes by having a scorpion and spider puppet attack a dog. During this enactment, Nick was involved with this dramatic action without any words. After some time, the therapist asked Nick about this story mentioning the attacks. Nick then spoke quite freely about the dog wishing he would die because he was abandoned and lonely. Nick was able to use this enactment to describe how he too felt like dying when his parents didn't understand him but were critical of his actions. After questioning about his thoughts about actual self-harm, Nick said that though he didn't want to actually die, he was very sad much of time. He said he thought it would be a good idea to let his mother know about the sadness.

When Kay returned, the therapist used the dramatic metaphors of the attacks on the dog to have Nick describe the depth of his sadness to his mother. While Kay was semisupportive of Nick's feelings, she again reported to Nick how helpless she felt to help him when she needed to always discipline him to change his behaviors. This interaction left both

Kay and Nick unsettled as they left. The therapist then asked Kay and Nick to mutually draw at least one positive event they experienced together the next week at home and to include some artistic representation of their feelings together.

Brianna was positive about her experience with her new therapist. She drew several figures of herself, her uncontrolled anger as a hurricane, and then added further artwork to change the storm. She was also able to develop self-portraits of herself experiencing different levels of anger. She and her therapist developed several self-control strategies she was to use the following week and use her drawings to record how successful she had been.

Before Kay and her children left, the therapists developed a plan together of having Nick and Brianna begin a series of individually oriented play sessions in which Brianna would try to use her artwork to control her anger, Nick would use play to further express his feelings, and Nick and Kay would use their home drawing to remind them of their positive feelings even if Nick's misbehavior continued. These drawings would be used to improve this relationship in future sessions. They also agreed that there would be joint sessions in future to address cooperation when a situation presented itself.

The main goals of these initial sessions were (a) to develop an understanding of the initial presenting problems of the children as well as the family as a whole that was shared by the parents, children, and the therapists together in ways that were expressed in more traditional verbal ways as well as in shared mutual play, (b) to introduce the family to how play expression could be related to these problems in addition to verbal discussion, (c) to use the play action to develop a shared idea of how future sessions would unfold to address family change, and (d) to develop some positive experiences to encourage the family's sense of hope.

In this example, Nick was presented as the main source of the family's concerns. Brianna's ability to control her anger was another secondary source of distress. The parents also expressed a sense of helplessness, which added to the overall stressful situation. The individual and joint play action was related to these concerns. Both the process and the themes of the mutual expressive play developed by Kay and Nick showed clear examples of the boy's isolation and his mother's inability to soothe him. Brianna's more directed drawings produced concrete examples of how she wanted to change and suggested metaphorical as well as practical ways for her to accomplish this. Finally the therapists were able to emphasize the more hopeful aspects these family members experienced in these first few sessions to help encourage further active participation.

OVERVIEW OF TREATMENT APPROACH

The previous case is an example of using play in working with families. This intervention makes use of Dynamic Play Therapy (Harvey, 1990, 1997a, 2006). Dynamic Play Therapy (DPT) is a family play intervention developed by the author (Harvey, 1990, 1993, 1994a, 1994b) in which the therapist assists children and their parents to become actively involved in play action together to address both the presenting concerns (usually identified as being problematic child behavior) as well as family relationships. DPT is based on the developmental concepts of attachment and attunement (Harvey, 2006) and specifically makes use of the positive feeling, relationship enhancement, motivational and creative aspects intrinsic to play to engage family members in mutual problem solving. The therapist uses both nondirective and directive activity as well as coaching to assist mutual play. This style is particularly useful when it is important to involve younger children directly in the therapeutic action.

Directive play oriented activities enable the therapist to address very specific problems that can be integrated with more nondirective play, which is often more useful to assist in improving relationships using interactive play metaphors. Directive and nondirective activities are used in both individual and family-oriented sessions. In the previous case example, Kay and Ron wanted the therapy to address the children's very specific problems: Nick's ongoing misbehavior (stealing, lying, running away) as well as his ongoing sad episodes and Brianna's anger and controlling behavior toward her brother. These adults were experiencing such high distress that more nondirective approaches, such as individual child-centered play therapy, appeared ineffective to them as they clearly requested action that helped to lower their children's behaviors that they had to live with daily. In this case, their helplessness could have decreased their motivation for treatment and impacted on their belief that therapy could be of use to them.

On the other hand, Nick clearly wanted to have a better relationship with his parents and have a feeling of being understood or feeling emotionally connected to them in spite of his misbehavior. Without such acceptance, it is likely that his feeling of being so sad that he wished to die would only continue. Any attention paid to his misbehavior problems, even in a therapeutic manner, had the risk of contributing to his alienation and also decreasing his willingness to participate. Brianna also wanted to feel positive toward her other family members despite her periods of aggression toward Nick. The therapeutic action of DPT attempts to address these dual underlying needs from the initial sessions through planning and development of the series of intervention steps by using the multipurposes of play (symbolic expression of feeling, metaphor making, creative problem solving, and engagement). Nick's and Brianna's specific problems could be identified and addressed in directed play action verbally linked to the family problems. The family relationship aspect could be addressed in joint playful creative engagement using such directed play as well as the mutually developed metaphors that emerged from the process. Importantly the experience of play is useful in creating a more positive emotional atmosphere in which the family would be more likely to trust and accept each other.

DPT intervention is conceptualized as being family oriented. Individual sessions are primary with the children and are used to help them develop their play to the point where they can both clearly express genuine feeling with intrinsic motivation and be organized so that their parents can participate. Sessions with parents address their feeling toward their children, helping them develop understanding and empathy to reinforce the basic positive aspects of their attachment as well as help develop practical management of their day-to-day problems. Parent sessions are also used to introduce specific home play activities that begin to address such problems. These sessions often have a more coaching aspect. Elements of both directive and nondirective play occur within individual sessions and family activities in a flexible manner. The overriding goal of all this activity is to have parents and children come together after their individual sessions or sessions in selected family subgroups to participate jointly. Use of free play improvisation is used around the problem themes that have been verbally identified and then applied to the home setting using joint discussion. Other family play therapists (Gil, 1994a, 2006) have also suggested using individual and family sessions with directive and nondirective intention flexibly within a single intervention.

In the previous situation, the family and therapists decided to begin with individually oriented sessions with the children to assist Nick and Brianna in developing play that was relevant to them. Nick's sessions were more nondirective to encourage his expression of feeling through his play metaphors and to develop mastery. Brianna's sessions initially were much more therapist directed to address her specific request of developing more control over her anger. Drawing was used as a way for Brianna to identify and monitor her feeling levels, albeit in a more creative extension of the usual traditional approaches. Interestingly, as she began to use her drawings to aid her in achieving this goal, her sessions became more nondirective as it became clear that she was experiencing a larger range of feelings than she could verbally express. The home drawings that Kay and

Nick completed (beginning with drawings of positive real home events) were therapist directed. Parent and child were helped to use their pictures to organize their home interaction and to include some focus on their positive experiences in order to encourage hopefulness between them. The discussion between Ron, Kay, and the therapist included use of simple behavioral techniques (using reinforcement charts) to help keep their attention on Nick's and Brianna's problems in balance with Nick's efforts to comply with them. It also provided a forum to discuss their children's experiences in the family more completely. These activities were seen as steps to have the parents, or at least Kay, join the children in mutual play sessions that could be organized around creative problem solving together. In this intervention each of these steps required a few separate sessions to accomplish.

BACKGROUND

FAMILY PLAY THERAPY

Schaefer and Carey (1994) identified a variety of play-related methods that integrate the practices of family therapy and individual play therapy as representing a new general approach that these authors identified as Family Play Therapy. The main goals of Family Play Therapy are to include even young children into the therapy, improve family communication, and make use of the family's innate creativity using various types of interactive play. Gil (1994) presented how interactive storytelling, art, sand play, and use of puppets can be used with families to address problems that arise particularly from the family interactions. According to Gil, play can be a very useful communication medium that helps adults more fully understand their children's point of view and emotional conflicts, especially when using the metaphorical qualities of play material. Ariel (1992) emphasized how make-believe play among family members can be useful in changing a long-standing pattern of family interaction that functions to maintain child problems.

DPT is a style of Family Play Therapy that includes parents and other family members by having them participate using interactive art, dramatic enactment, movement, storytelling, and video making often in an integrated way (Harvey, 1993). DPT emphasizes the role of play to help families creatively improvise in ways that communication and problem solving are emergent. The role of the therapist is to guide and coach these play collaborations particularly to help parents match and then extend their children's play initiatives. The goal of having families participate in extended play episodes is to make use of the experience of mutual play activity. Schaefer (1993) has pointed out that the experience of play itself has several curative benefits that are intrinsic to play such as relationship enhancement and intimacy, creativity, intrinsic motivation, and a sense of mastery among others.

In DPT the therapist helps families play together so that children can express a range of feelings while placing parents in a positive, responsive, and supportive role throughout the expressive action. The therapist organizes interventions around the principle that children's problems occur in a family context where relationships are strained. These relationships lead to intimate interactions that contribute to an overall negative emotional atmosphere that stands in the way of problem resolution. Interactive play can alter these negative interactive patterns by increasing positive feelings among the family members as they use play in ways to address and focus on their family problems.

One of the initial goals of mutual play action is to help parents recognize and become attuned to their children by changing their play to match and extend their children's play expression (Harvey, 1997c, 2003). It is in the parental recognition and extension of the child's play initiatives that much of the therapist-directed activity occurs. It is during these episodes of mutual play, which is more attuned, that positive feelings between the players emerge. Therapist direction also occurs in connecting the resulting play episodes to the specific family problems that have been verbally presented. This action of developing play metaphors that have direct relevance to the presenting problems is the next focus. Family problem solving often happens at this time.

A basic assumption is that families have the creative ability to address their conflicts in a naturalistic manner and that they can and do use play in their ongoing day-to-day life to both problem solve and resolve their basic emotional conflicts. When their emotional distress becomes too high, families lose this resourcefulness, and their basic everyday playful exchanges become negatively impacted. Interactive play, when it occurs, can become full of tension, be disconnected, and lose a sense of good feeling and shared fun (Harvey, 2003). In this situation, children's emotional and behavioral difficulties become amplified, and the family interactions that develop tend to maintain such difficulties. In DPT inventions, the therapist helps families experience and recognize the intrinsic motivation and positive emotional feeling states that can be mutually experienced in play action and then to develop playful resourcefulness to address and problem solve their more specific concerns.

The case presentation is a good example of this situation. Nick's ongoing behavioral disruptiveness in the family created, and was highly related to, a stressful emotional atmosphere within the family. This atmosphere was continually being re-created in many of the family's interactions, such as Brianna's attempts to control her brother, Nick's many episodes of crying, open arguments between Kay and Ron about discipline and their intent to stay together as a couple, the birth father's refusal to recognize and allow for intervention, and all the family members' reported feelings of helplessness and anger. In this state, the parents were unable to interact with either child in a way that created an emotional sense of security or empathic understanding between them. These parents and both Nick and Brianna showed little spontaneous playfulness in the day-to-day interactions. They had also lost their creative flexibility that might have helped in family exchanges. Few of the family's daily interactions had natural play, humor, intrinsically oriented problem solving, or imagination that could be used to address ongoing interpersonal stress as well as produce an atmosphere in which problem solving could occur.

This emotional dilemma was particularly revealed during the interactive play between Nick and his mother when he was developing the dramatic episodes of dangerous and deadly attacks on the animal (by the scorpion and spider) he had identified with (dog). Even when Nick was helped to tell his mother about his (and the dog's) strong sadness and thought of death, Kay's worry about his ongoing and future misbehavior interfered with her ability to fully empathize with him and appreciate the creative expression of his personal dilemma or join his play in a way that could change the present moment. Despite their clear desire to share close feelings with each other following Nick's statements to his mother about wanting to die, Nick and Kay experienced emotional stress and distance. Their play action was leading them in separate emotional directions. Both verbal and play intervention were required to change the quality of this interaction.

USE, PURPOSE, AND IMPORTANCE OF PLAY

NATURAL INTERACTIVE PLAY

A central premise of DPT is that creativity occurs spontaneously and naturally in any family throughout daily everyday episodes. This ability contributes to the family's skills in coping, adapting to change and adversity, and motivation for problem solving, and it influences the general emotional climate. Past unresolved emotional events negatively affect a family's creativity. Much of this process is unconscious, especially among children. In a more normal situation, families can solve their problems and feel positively about each other at the same time.

One very concrete way natural creativity is both expressed and generated in families is in the spontaneous interactive play between parents and children. Such play can emerge seemingly at any time and introduces a shared positive feeling among the players and is improvised to meet present situations. Family members also discuss their play easily in encouraging and organizing ways. In families experiencing significant stress such play and conversation is difficult to generate.

This interactive behavior can be thought of as an activity that generates attachment as different family members attune or join such play in ways that match and fit into the improvisation. One outcome of such attuned play is that it generates pleasure among the players. This shared pleasure (the fun of play) leads family members to try to play again and then again. It also contributes to the experience of hope. In this way interactive play has an important restorative function in family life.

Researchers and clinicians (Harvey, 1994c; Stern, 1985; Tortora, 1994) interested in infant-parent play observe how playful exchanges develop a natural dance or choreography involving eye contact, smiling, and responsiveness in mutual nonverbal communication. As a child grows, such games become more elaborate using sound and face making, verbal exchanges, and larger sensory-motor play involving running, jumping, and tumbling often with the aid of and interaction with parents. In preschool years, mothers, fathers, and young children engage in an extended range of dramatic role-playing in addition to the wider variety of physical games they are now able to accomplish. A visit to any playground or park where young children and the parents are playing reveals a wide variety of such family activity. This play develops humor and storytelling as families mature. In observing this activity one is struck by the spontaneity and naturalness of the participants and how such play generates a spirited and emotional joining. This bonding is mostly characterized by a special state between the players that consists of improvisation and enjoyment of each other, and in which conflicts can be resolved flexibly. A family also verbalizes freely about such episodes, describing what is occurring, giving verbal meaning to the play activity, and at times planning these activities.

Images and themes related to emotionality and interpersonal conflicts are repeated in these episodes. When families can continue their play interactions, these themes can resolve and transform emotional tensions that place intimate relationships at risk. Such adjustment occurs especially when they as the players are enthusiastic and such themes are discussed in positive and meaningful ways. In this way, these episodes become an antidote to highly charged emotional events associated with conflict, trauma, and loss.

Examples of common themes include a young toddler who has just been injured casting his willing mother or father into the role of doctor to cure him; a young infant who is frightened by separation initiating nonverbal communication to cue her parent's secure embrace, physical holding, and visual attention through face games; a preschooler's playful exploration of a role in which he magically transforms himself into an all-powerful hero problem solver under his mother's watchful eye and sometimes active participation. Even a teenager's use of humor while in conflict with his parent can be quite soothing and help to restore a sense of family. In each of these examples, the play partners talk freely among themselves about the meaning and positive outcomes of their play actions. Clearly in the best of circumstances, families' mutual play produces a healing process in which their mutual creativity, imagination, and verbal meaning attribution transforms such themes in a way that the players experience affiliation, intimacy, attachment, and affirmation. Quite often such activity has a very light emotional quality that is characterized with laughter, an easy exchange of ideas and action, and has a relaxation to it. When natural play is occurring in a family, solutions to interpersonal problems emerge quite easily either during the play through the metaphors, in the process of reconnecting, or when the family has had a positive emotional experience that restores their problem-solving abilities in a more subtle way.

When the emotional atmosphere of a family becomes negatively impacted, such as occurred in the previous case, their ability to generate natural play becomes lessened or it only occurs when there is little or no stress. Sometimes natural play disappears altogether. In such a situation, families have a difficult time sustaining play during interventions. The play episodes can develop oddly and have periods in which the play expression breaks down or stops. At times, play can become an emotionally painful experience for all the players. Nick's secret dramatic enactments of the dangerous attacks on the dog were an example of this. Nick did not bring the dog into the house Kay was building, and she didn't notice the spider's or scorpion's stings. Nick did not verbalize what was going on, and Kay did not ask. When the therapist attempted to use the dramatic image to discuss Nick's feelings, neither he nor Kay were able to feel emotional catharsis or closeness from their interaction. It was as if Nick's feelings of wanting to die were still hidden and Kay could not see to respond.

The first therapeutic task is to help the family identify when such moments (or whole episodes) occur in their play and then to find ways to have them rediscover their natural playfulness and apply it to their situation. Put simply, in this style of intervention, the goal is to help families develop or restart play that has broken down between them.

INTEGRATING DIRECTIVE AND NONDIRECTIVE PLAY IN INTERVENTIONS

The therapist needs to make several decisions to guide the use of play with families to help them develop and use their spontaneous play productively. It is not enough to simply ask family members to play together, as it is likely that their problems will merely continue in the therapy room. Gil (2006) describes an approach to working with abused children and their caretakers that integrates directive and nondirective approaches to address an individual child and family's needs on a case-by-case basis. This author advocates assessing each situation to understand how the family, cultural, and other situational contexts might apply and then use combinations of the symbolic nonverbal techniques of expressive therapies with more focused cognitive behavioral procedures to address distressing thoughts and emotions in ways that even young children can experience mastery over the threatening and overwhelming experiences.

Yasenik and Gardner (2004) have put forth a model that integrates various approaches to play therapy to help therapists guide decision making for all types of populations. In this model, interventions can be placed within two dimensions: nondirective to directive and unconsciousness to consciousness. In nondirective approaches the therapist primarily follows the child's lead; while when being directive, the therapist is more active and participates with the play and thereby has influence on the resulting expressions. When play action is in low consciousness, actions are not verbally linked to thoughts, feelings, or problems by the therapist. When play has high consciousness, the therapist uses verbalization to discuss and link play action to presented problems with the player, including thoughts and feelings. The therapist can use both these dimensions together to intervene in such a way as to allow (a) free improvisation in which the player is left to express their own initiatives while the therapist follows as the witness of such expression, (b) the therapist to participate as a cooperative play partner often taking on roles which compliment the play action, (c) the therapist to begin to use verbalization that connects play expression to the presenting real-life problems, and (d) the therapist to use directed structured play action to address the presenting problem together in verbal conversation with the player.

This model can be applied to family play intervention by adding a third dimension that varies from the child's solo participation to inclusion of family members. In this way therapy choices range from having (a) an individual child playing in a nondirective manner with the therapist only, (b) including family members (and therapist at times) as co-players in play episodes which are more improvised, (c) the therapist using verbalization and other techniques (such as home play activities or other expressive modalities) to link play action to the thoughts, feelings, and behaviors associated with real presenting problems with family members in addition to the identified child, and (d) the use of therapist-structured expressive activity that directly represents the problem/solution and includes conversation with relevant family members.

When other family members are present with the child, the therapist can also use the observed present interactive behavior between family members as a way to link play expression to real problem interactions that can develop more consciousness to family communication about problem solving. Such linking occurs as the therapist begins to notice the play breaks that negatively impact the spontaneous expression caused by interaction that family members are often not aware of. The use of interactive behavior as a link to more conscious play helps intervention move easily from expression that addresses interpersonal threat and facilitates relationships and alliance building to activities that focus on specific issues.

By way of example, some children begin to withdraw from their interactions with their parents when they begin to experience basic insecurity. In one session, a 5-year-old girl began to draw on the very edge of a large piece of paper while her mother completed an inviting series of parks and shops over the entire page in an activity where the child and her mother were asked to draw their home and a village together. The girl had unfortunately been separated from her mother for several months and had experienced abuse while living with another family. The more places the mother created, the further away and more constricted her daughter's marks became. As the therapist noticed this break or change in the spontaneous activity, he directed the child to create her own village on another piece of paper a slight distance away from her mother's and had her mother create a harbor and an airport in her village on what was now her own personal drawing.

In the next part of the session, the therapist directed the girl and mother to begin to use other art material to make forms of transportation to help them visit each other's villages that were now located in different countries (different pieces of paper). This step led to a dramatic enactment of the mother and daughter journeying to and from each other while the therapist used storytelling to highlight the emotional aspects of this within the metaphor of the symbolic action. This session was then used to introduce more specific play episodes during office visits as well as in home activities that addressed the mother's central presenting concern with her daughter's withdrawal from her and the child's ongoing sleep problems. The final step in this intervention included having the mother and daughter develop and then rehearse a bedtime story that they used to help create a calm bedtime. This story included aspects of the story drawing of the journeys that were enacted during their earlier therapy sessions.

In this example, the mother and daughter began the expression in a nondirective manner. The resulting activity however was leading into expression that was an emotional conflict-laden situation. The therapist's direction helped the mother and daughter creatively address this conflict and then develop a new solution quite naturally. As this dyad continued to play together, their next series of expressions became more attuned and generated a positive atmosphere. The two players then were able to create a focused answer to their initial dilemma. In this way, the therapist was able to move from mutual play where the mother and daughter were partners involved in unrelated play to their presenting concern to play that was directly related to it. The therapist and family could have direct as well as symbolic play conversation about the feelings of fear, abandonment, and reunion. The therapist was able to use the interactive behavior to consciously link the expression until it was a direct expression of the verbally defined presenting problem. By including both directive and nondirective play, the emotional significance as well as the relationship aspects was included in the final solution.

The above example describes the process of adding more directness and consciousness to structure play that addressed a specific issue. However, therapeutic action can also move toward less structure and consciousness when the family or child become too threatened or overwhelmed. In another situation a mother was directed to help her two children enact a scenario of constructing their own houses from a number of pillows and other play material in the play room. Very soon the children began fighting with great intensity over dividing the material and how much room each house should take. The mother became helpless as the argument escalated. What began as a directed, conscious activity with several family members to address a real family concern about developing more cooperation turned into a real drama about distress and helplessness. This event was much like what many home episodes were like. These children and their mother lost their ability to use play to generate relationship and good feeling. No problem solving could develop.

The therapist then set up the next several sessions as individual nondirective play initially with the children alone and then with the mother and only one child at a time in dyads. These sessions were supportive, and the therapist encouraged the play action to be directed by the children's lead only. No conscious link was made to the previous disruptions. When the mother did rejoin as a play partner with each child individually, the play helped to restore a sense of intimacy and security for each mother/child dyad. Some amount of shared positive feeling spontaneously emerged. Interestingly each child introduced a theme of loss during the nondirective play that had not been discussed at intake. Such themes were then included with the mother using the more directed and conscious elements of intervention just presented.

The basic criteria for the therapist to use a particular style of intervention are based on the child's and/or family's distress level as observed in the level of successful play. In general, as the family begins to show engagement and success with attuned play, the more the therapist can use conscious play activity and the more specific problem themes that can be introduced. When interactive play becomes too overwhelming and is less successful, more nondirective play is started and individual play options can be used. Steps of interventions generally develop from unconscious nondirective individual play toward unconscious partner play with other family members to achieve attuned play that can begin to generate shared positive feeling. Therapists then use such play along with homework to link this kind of conjoint expression consciously with verbalization to family concerns. Interventions usually end with the therapist and family verbally directing play action to directly link play to their main problems together.

TYPES AND USES OF DIRECTED PLAY ACTION

Structured activities are used to help families develop more cooperation and shared problem solving directly. These interventions share many of the principals of (a) Cognitive Behavioral Play Therapy (Knell, 1993), including having activities that have a strategy for developing more adaptive functioning, have a goal, and are introduced as experiments in problem solving, and (b) Time-Limited Play Therapy (Sloves & Peterlin, 1994), including the expectation of high therapist involvement and activities that are developed around a central theme. DPT adapts such principals to fit the use for families.

The following activities are examples of common play structures that can be used in therapist-directed interventions to help achieve more coordinated and attuned play. When such play is used for specific issues, the directions help to highlight and link specific problems to play expression with more consciousness. The following partial lists are provided as concrete illustrations of how mutual play expression can be used to provide focus on presenting problems or assistance with developing attuned play.

This author has found that play structures used in family situations need to have very simple and basic organizations to be able to highlight and define problems in play terms while also offering room for playful improvisations to generate solutions. The following examples demonstrate a few of these basic structures that have been successful in accomplishing this. A great many more unique structures can emerge from working with the specific situations an individual family brings. Such unique structures are developed based on the idea of having simple play action link to family difficulties through conscious metaphor.

Neutral Play Structures

These activities are used mostly during the initial phase of therapy to evaluate style and quality of family interactions (see Harvey, 2000, for a complete list and description of use in assessment). However, these activities can be used at any time in the intervention to help build attuned play between parents, siblings, and children. Movement activities include follow the leader, with everyone getting a chance to be leader; parents swing their child into a pile of pillows; tug of war; parachute games with children running under the material as it is raised; races in which the winner is the fastest, slowest, going backward, on the floor, and so on with different family members selecting criteria for winning.

Art activities include each family member drawing a house with themselves inside, then collaboratively drawing a town, and finally showing themselves coming out of their houses to interact using storytelling to elaborate; whole families drawing various family portraits collectively and individually; and drawing the family on an island together. Dramatic activities include having the family build a house with pillows and using soft animals to enact a story about a family; improvised family play together, having parents leave and then rejoin the children. Such activities are often extended by having the family begin in one play modality (such as movement) and then extended into another modality (such as art) and then adding a story aspect to the interaction.

Play Structures to Address Specific Problems

To address fearfulness, have the parent and/or child chase away or eliminate a monster (either created with art materials or soft animal). To encourage more appropriate expression of anger, have the child and/or parent kick pillows piled over like a volcano followed by drawings and stories of the activity. To address ongoing arguments, have each family member try to out scribble the other, using scribble art as the argument, and then draw various images in the resulting tangle of lines and use the images in storytelling. To increase problem solving, have the individual or family collectively draw the problem on one side of the page, and the solution on the other. This can be done with animals to encourage more symbolic dramatic storytelling.

Individual and various family members can create various types of maps indicating the beginning of the problem and the solution or end point and all the various barriers and passageways in between. These maps can be elaborated according to developmental level of the children involved. Dramatic enactment and storytelling can be very useful in extending and individualizing the type of journey being taken together including the barrier and traps that inhibit these solutions in therapy. A variation of this idea is to take a basic beginning place and ending place of the problem and have the family work together to design their own game with the goal of arriving at the end point indicating the resolution of their presenting problem. Such games resemble typical board games with cards, penalties, and so on. Each of these game aspects can be designed to be related to family life. (See Harvey, 1997, 2001, and 2003 for more activities and descriptions of application.)

HOMEWORK ACTIVITIES

Homework is particularly useful in (a) extending positive feelings or problem solving from the office to the home setting and (b) linking play expressions to actual day-to-day problems so that families can use the improvisation in play to reflect and facilitate change in their home life. Mutual artwork has proven the best modality for such homework. Some examples of homework include having the parent and child draw themselves participating in a positive experience together and then add a representation of conflict to this picture to create a collage. Versions of these pictures can be used to create maps that address problem resolution. These productions are brought into the session and extended through more play expression or conversation.

RITUALS

Imber-Black and colleagues (1988) introduced the concept of using rituals in family therapy to help resolve conflicting and complex emotional situations. The current author has used expressive play structures to have families develop their own rituals to address important to very significant family events. The use of play modalities is helpful with the inclusion of younger children. One of the basic rituals is developed from the idea of gift giving. This ritual can be used in many situations to address complex intimate relationships. This ritual is often very useful during the termination of therapy as it can address the emotional content of the therapeutic alliance between the therapist and children as well as between therapist and family. The play action includes having the family (either individually or as a collective) and the therapist use art materials to create collages of their experiences together and then exchange these gifts during the final session.

Another series of rituals is based on recognizing changes in the family or in the status of the children. The action of this ritual is more dramatic in nature and is developed by identifying a part of the room as representing different situations and then having the family become involved in having the identified child move between these locations. This ritual has been used to signify birthdays (e.g., child moving from 6-year-old land to 7-year-old land), children moving from one family to another (e.g., between foster or adoptive family placements), or to symbolically represent major moves between countries or cultures (e.g., from the United States to New Zealand, or leaving a native cultural context to attend a school of the majority culture). Important rituals can be developed to address significant losses the family has experienced, such as the death of other family members. Such a ritual needs to be planned for and developed with sensitivity to each family situation.

Finally, therapist storytelling can be used to summarize important events. Such stories are composed of the images developed in the play, and recognize and respect the strong and complex emotional situation. Such stories are built around the positive outcomes and resilience of the family members involved.

AN APPLICATION FROM THE CASE EXAMPLE

An example from the intervention involving the family presented in the beginning of the chapter will be used to illustrate how both directive and nondirective approaches can be used with families in an integrated manner to facilitate the emergence of natural play and focused problem solving. Some of the goals that emerged from the initial evaluation sessions included helping the family develop shared cooperation, particularly between Nick and Brianna, as well as helping the family as a whole develop a sense of hope that things could improve. The family and therapists discussed how these goals could be developed in play action as well as in their out-of-therapy interactions.

The children began with individual nondirective sessions to help them develop more confident expressions of their emotions. As the sessions occurred at the same time and there was only one playroom with a single set of materials, Nick and Brianna were helped to cooperate in dividing the materials prior to beginning their respective appointments. When the two siblings could accomplish this after some practice, the family therapist directed them to have a session together in which they would play cooperative games together. Following this successful activity using a commercial board game, the therapists then helped them create and play their own game together using the art materials. The game was then extended using some dramatic enactment. The game included cooperative challenges with appropriate verbal ways to help this occur in the home as well as penalties for over-the-top arguments.

At the beginning of the next session, Nick and Brianna stated they both ''just wanted to play together.'' As the therapists had observed that the children had been able to experience both focus and enjoyment in the more directed activity, they decided to encourage the siblings to improvise together. During this episode, the two children explored several different media, including the musical instruments. Nick started to enact singing saying that he always wanted to sing and dance. Brianna then initiated a dramatic scenario in which she helped Nick with costumes, set up a stage and imaginary TV studio, and put herself in the role of a director. She then proceeded to take the lead in developing a mutual enactment of a make-believe version of a TV show she identified as the ''makeover artist.'' Brianna took the role of the hostess of the show, while Nick became the person who was ''made over'' as a singer. They had so much fun that they decided to invite their mother to participate the following week with the therapists' support.

The play moved from nondirective to directed co-play, to nondirected family improvisation during which time the therapist could begin to make verbal links between the play and the central identified problems. This episode then became central in follow-up discussions, as change in the home setting was much like a family makeover. Nick, Brianna, and Kay all had an immediate understanding of this image and were able to use it productively to remind them that they could cooperate together and generate creativity, problem solving, and hope as a family. The story of the makeover artist became a central theme during the termination as well.

SUMMARY

Often families, and the parent-child relationships in particular, can be a major influence in development and maintenance of child problems. Child problems stress the parents, who then in turn interact negatively with their children. This continuing interpersonal stress can affect the emotional climate of a family in a way that natural problem solving cannot develop even when interventions address specific problems. When children present with mental health problems, the qualities inherent to interactive play, such as intrinsic motivation, relationship enhancement and communication, metaphor making, and a shared sense of fun, can be used to both help family members restore a positive emotional feeling with each other and address more specific problems. When family members develop metaphorical play together they share involvement and engagement in creating something together and can then focus their creation on specific problem solving simultaneously with everyone developing a part. Therapeutic action requires the therapist to integrate both directive and nondirective techniques to help families develop the shape of interactive metaphors that match their unique context and emotional needs.

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SECTION VI

THERAPIST SELF-CARE

THIS FINAL SECTION was included as it is an important topic that is rarely addressed by child and play therapists in the literature. Indeed it is not often addressed in the therapy field. Yet, many child and play therapists deal with difficult clients and their families on a routine basis. Many child and play therapists work with children and families who have suffered sexual abuse and trauma. Work situations may not be optimal, and the pressures of managed care, credentialing bodies, and productivity demands lead to stress. As stress mounts, without regular self-care to offer relief and relaxation, the likelihood is great that if left unabated it will lead to burnout, which can have serious physical consequences for the individual. It also has serious professional ramifications resulting in either leaving the profession or in becoming a less effective clinician.

The authors offer a research-based look at self-care and how best to implement it in our daily lives. This chapter offers many unique practical and research-based strategies to follow on a regular basis. Self-care is an ethical imperative for therapists, ourselves included. Without self-care, we will not be adequately able to help others and prevent harm to them. Furthermore, play is not just for children or adolescents. It transcends all ages. Yet, many of us forget to give permission to ourselves to play and release our daily stress. This chapter will hopefully remind us to play!

CHAPTER 22

Self-Care for Child Therapists: Leaving It at the Office

JOHN C. NORCROSS
ATHENA A. DREWES

APPROXIMATELY 20 PERCENT of children have a diagnosable mental disorder, and 10 percent of these children have extreme functional impairment. These numbers translate to 11 to 14 million of the 63 million children in the United States suffering significant impairment. Moreover, 69 percent of children and youth who currently use mental health services have used them in the past (Meichenbaum, 2008).

We clinicians encounter many of the children and youth in these statistics; we clinicians regularly witness and unfortunately absorb their suffering. We are challenged each day in our work to deal with a myriad of difficult cases that ultimately can wear us down physically and emotionally.

As the stress mounts, we can suffer intrusive thoughts about our clients, including their imagery, their horrific stories, and their traumatic experiences. We may begin to daydream or become distracted when clients are speaking with us; we may distance ourselves from our colleagues and friends; our enthusiasm may wane; our clients begin to blur in our mind; we are tired all the time. We don't want to talk about work, and slowly our hopelessness in dealing with the failures of treatment and seemingly insurmountable odds turns into anger. We have no patience; we lose our sense of humor; we have no time for fun. We begin to think about leaving our profession, our work.

Our colleague, Gerry Koocher (1999, p. 25), who works with children and families confronting life-threatening illnesses, has written movingly of his work-related nightmares. One recurrent dream is that Gerry is in line for a roller-coaster theme park ride.

> As the line winds down slowly toward the start of the ride I notice that I'm standing among friends, relatives, and dozens of bald-headed or bewigged children, several of whom I recognize as patients I treated before they died from cancer. Suddenly we are on the leading platform, and I notice a sign with large red letters: ''WARNING! Up to 40 percent of riders fall to their deaths. Check your safety bar.'' I find myself seated in the last seat of the back car. I pull the safety bar toward me and hear a reassuring ''click'' as it snaps into place. As I look up the car begins to roll down the chute, and I notice that many of the riders in front of me have not secured their belts. I feel a desperate urge to reach out and help, but am locked in my seat and cannot help. We plunge into darkness that is broken by the flash of a strobe light. With each flash I see more empty seats in front of me. There is nothing I can do.

His distressing dream encapsulates the internalized distress that many of us experience in working with disturbed—and disturbing—children. The American Psychological Association's Colleague Advisory Committee has promulgated a Stress → Distress → Impairment → Improper Behavior continuum. Of course, not all distress leads to impairment, but the research suggests that it frequently does.

Decades of cumulative research rebut the illusion of the invulnerable psychotherapist. The risks of practitioner distress are real, bordering on the norm. One study (Pope, Tabachnick, & Keith-Spiegel, 1987) found 59.6 percent of mental health professional's surveyed acknowledged ''working when too distressed to be effective'' even though many of them acknowledge knowing that doing so is unethical. A subsequent study (Guy et al., 1989) found that 36.7 percent of psychologists stated that their distress decreased the quality of patient care. Each of us, all of us, is vulnerable to distress leading to impairment.

In this chapter, we address the self-care imperative of child psychotherapists. We begin by reminding therapists of the ethics and ironies of self-care and then briefly review the compassion fatigue and other stressors practically endemic to the field. We conclude by outlining 12 practitioner-recommended and research-based self-care strategies.

THE ETHICS AND IRONIES OF SELF-CARE

Self-care is an ethical imperative. Every mental health discipline (except psychiatry) includes in its ethical code a provision about the need for self-care by the clinician. For example, the American Psychological

Association's Ethical Code (2002, p. 1062) makes psychologists aware ''of the possible effect of their own physical and mental health on their ability to help those with whom they work.'' The American Counseling Association's (2005, p. 9) Code of Ethics also reminds counselors to ''engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.'' Further, the Code states ''Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment. . . .''

Such ethics standards focus on existing problems and conflicts, which certainly represents sage advice. But a broader interpretation would be to prevent such circumstances from even occurring (Barnett, 2007). Self-care is not restricted to intervention after professional competence has been compromised; it is a continuous, proactive process throughout our careers.

Without attending to our own care, we will not be adequately able to help others and prevent harm to them. Psychotherapist self-care is a critical prerequisite for competent patient care. In other words, self-care is not simply a personal matter but also an ethical necessity, a moral imperative (Carroll, Gilroy, & Murra, 1999). We gently urge you to challenge the morality of self-sacrifice at all costs and to consider the indispensability of self-care.

The point segues into the irony of psychotherapist self-care: not availing ourselves of what we provide or recommend to clients. We often feel hypocritical or duplicitous—suggesting to others that they work less, exercise more, renew themselves, and so forth while we do not take our own advice. How often do we sit with patients encouraging them to ''relax and take a vacation,'' while calculating our lost therapy revenue and airfare and concluding we can't afford to take the time away from the office right now? How often do we experience the dissonance of ''spending several hours a day playing Uno, Checkers, and War in the name of play therapy and coming home in the evening and casting my children's requests aside in the name of fatigue?'' (Penzer, 1984, p. 54). Many psychotherapists candidly admit giving more time, energy, and devotion to their practices than to their spouses, children, or themselves.

Mental health professionals frequently enter the profession out of a genuine and intense desire to help others in a meaningful way. Yet, this focus on the needs of others complicates our balancing act: effectively caring for ourselves while caring for others. Sapienza and Bugental (2000, p. 459) put the self-care irony bluntly: ''Many of us have never really learned how to take the time to care and to nourish ourselves, having been trained to believe that this would be selfish. . . . Nor have most psychologists taken the time to develop compassion for themselves, and compassion for their wounds.''

Not that child therapists oppose self-care, far from it. Instead, we are busy, multitasking professionals dedicated to helping others but who frequently cannot locate the time to help ourselves. Clients, families, paperwork, colleagues, students, and friends frequently assume priority. The ideal balance of caring for others *and* for ourselves tends to favor the former.

Just as being a lawyer does not necessarily make one more honest and being a physician does not necessarily make one healthier (Norcross, 2000), so too does being a psychotherapist *not* make one automatically more proficient at self-care. In fact, it is frequently the converse in a profession in which people enter to help others.

It is easier to be wise and mature for others than for ourselves. If you are still feeling a little hypocritical, sheepish, or guilty about not practicing what you preach, then join us and the crowd. We are far more adept at recommending self-care to others than practicing it ourselves, as our families and friends will readily attest.

STRESSORS OF THE IMPOSSIBLE PROFESSION

In *Analysis Terminable and Interminable*, Freud (1937/1964) observed that psychotherapy/psychoanalysis was ''the third of those 'impossible' professions in which one can be sure beforehand of achieving unsatisfying results. The other two, which have been known much longer, are education and government.'' Indeed, the lack and uncertainty of therapeutic success is typically cited as one of the most stressful features of conducting therapy. Almost 75 percent of practitioners highlight it as a significant hazard (Farber & Herfetz, 1982).

Of all the stressors culled from the vast literature, physical isolation, emotional isolation, patient behaviors, working conditions, therapeutic relationships, and the industrialization of mental health rank highest (Norcross & Guy, 2007). Plus there are the additional stressors of paperwork that is needed to be completed quickly, demands of meeting productivity requirements, and unexpected audits by credentialing bodies.

Among the distressing patient behaviors for child therapists are repeated goodbyes, which are part and parcel of the treatment process. Repeated farewells can become difficult for the clinician over time, resulting in a reluctance to attach or to care deeply (Guy & Brown, 1993). Children's suicidal statements and acts, aggression toward the therapist, severe depression, and their premature termination are reported as the most distressing (Deutsch, 1984; Farber, 1983; Kramen-Kahn & Hansen, 1998). More than one in four interns/trainees will encounter a client suicide attempt, and at least one in nine will experience a completed client suicide (Kleespies, Penk, & Forsyth, 1993).

So let us begin by saying it out loud: Practicing psychotherapy is often a demanding and grueling enterprise. Freud correctly characterized it as an ''impossible profession.'' Mental health professionals are regularly engulfed by their clients' pain and disability, are routinely confronted by conscious and unconscious hostility, and are ethically bound to secrecy of the most troubling confessions and occasionally the most heinous of crimes. All of this is accomplished under unremitting pressure in frequently less than humane working conditions with interpersonally disturbed patients (Norcross & Guy, 2007). Emotional depletion, physical isolation, and psychic withdrawal seem natural responses. One is tempted to accept the dramatic assertion that ''If we ever really considered the possible risks in getting involved with a client, we would not do so for any price. Never mind that we will catch their colds and flus, what about their pessimism, negativity, and psychopathology'' (Kottler, 1986, p. 8).

Burnout and Compassion Fatigue

Stress is an inevitable part of life and, typically, work. Of course, a certain amount of stress is normal and necessary for survival, but its beneficial aspects diminish when it is severe enough to overwhelm one's ability to cope effectively or to work productively. Intensive and prolonged stress can lead to a variety of short- and long-term negative health effects (Middlebrooks & Audage, 2008).

A nonspecific consequence of occupational stress is burnout, a psychological syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Goldberg, 1998). The chronic conditions of perceived demands outweigh perceived resources (Gentry & Baranowsky, 2008).

Compassion fatigue (or secondary traumatic stress) refers to the adverse reactions of helpers who assist trauma survivors (Figley, 1995). It results from the combined effects of a primary trauma (from the helper's past), secondary trauma (of repeatedly hearing the trauma stories of the clients), and burnout to produce painful symptoms in caregivers. Further, vicarious traumatization is the ''negative effects of caring about and caring for others,'' and ''it is the result of empathic engagement with the client's traumatic material'' (Pearlman & Saakvitne, 1995, p. 31). Empathy is our greatest asset, but it can also pose our greatest liability.

Fifty percent of professionals who work with trauma clients report feeling distressed, and 30 percent of trauma therapists report experiencing ''extreme distress'' (Meichenbaum, 2005). This distress is exacerbated by the fact that around 30 percent of therapists have experienced trauma during their own childhood (Figley, 1995; Kohlenberg, Tsai, & Kohlenberg, 2006; Miller, 1998). Clinicians with a history of personal trauma, who are beginners and new to such work, whose supervision experience is limited, and who deal with high job stress may be most susceptible to developing vicarious traumatization (Meichenbaum, 2005).

As child therapists, we are called upon to witness the unspeakable brutalities of humanity—violent crime, childhood abuse, extreme loss, and terrorism among them (Sexton, 1999). Some therapists experience PTSD symptoms similar to our clients, such as intrusive thoughts, nightmares, avoidance, and relationship distress (Figley, 1995; Salston, 2000). The terms vicarious traumatization (Pearlman & Saakvitne, 1995), secondary traumatic stress (Figley, 1995; Stamm, 1995), and compassion fatigue (Figley, 1995) have come to stand for the tangible negative effects therapists suffer when dealing with trauma survivors.

SELF-CARE STRATEGIES

No single self-care strategy is most effective in ameliorating compassion fatigue and other occupational stress. Rather, research confirms that a variety of self-care strategies make the difference (Norcross & Guy, 2007). Effective self-care must be tailored to the individual practitioner.

The failure to consider the individual motives, needs, and vulnerabilities of the particular child therapist leads to common and spectacular mistakes. Much of the well-intended practical advice on self-care bandied about feels hollow and general. One-size-fits-all treatments never accommodate many people, be it our clients or ourselves. We have learned—and repeatedly relearned—that sustainable self-care must occur in the context of, and be responsive to, the emotional vulnerabilities and resources of the individual clinician.

A complex matrix of interacting variables—family background, training experiences, characterological vulnerabilities, sociodemographic diversity, professional discipline, personal values, practice setting, theoretical orientation, *ad infinitum*—reciprocally determine the eventual ''distress'' of the clinician. Similarly, what works for one of us in self-care—more contact with professional colleagues or more vacations—may well backfire for another of us. What works well at one point in one's career may not be as effective at another. Changing circumstances, needs, and preferences must be considered (Mahoney, 1997).

Although research on therapist self-care has not progressed to the point where randomized controlled trials (RCTs) have been conducted, there is a robust and growing body of empirical research. The research results, generated by diverse methodologies and numerous investigators, converge on 12 effective self-care strategies for therapists (Norcross & Guy, 2007). And these same strategies probably prove effective for ordinary people as well, contrary to rumor, psychotherapists too. In Table 22.1 we outline these 12 core strategies (see Norcross & Guy, 2007, for amplification and self-care checklists for each) and below we highlight strategies specifically for mental health professionals working with children and their families.

Table 22.1

A Précis of 12 Self-Care Strategies

1. Valuing the Person of the Psychotherapist. Self-care begins with self-awareness and personal commitment. Assess your self-care as you would a patient's. Indentify your vulnerabilities and sabotages. Writing, journaling, logging, or self-monitoring can track your progress. Secure honest feedback from loved ones and coworkers. Build on your successful self-care as opposed to simply adding new items onto the list. Make self-care a priority, not an indulgence.
2. Refocusing on the Rewards. Re-experience the privileges of the profession. Notice the life rewards associated with clinical work. Feel the career satisfaction. Practice the mental set of gratitude. Recall Emerson's words: "It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself."
3. Recognizing the Hazards. Begin by saying it out loud: Clinical work is a demanding and often grueling enterprise. Affirm the universality of occupational hazards by sharing with colleagues. Beware the classic stressors of the "impossible profession": emotional isolation, distressing patient behaviors, inhumane working conditions, physical exhaustion. Practice acceptance of the inevitable stressors. Cultivate self-empathy. Adopt a team approach.
4. Minding the Body. Don't overlook the biobehavioral basics. Protect your sleep. Insist on bodily rest. Secure adequate nutrition and hydration during the day. Engage in regular physical exercise. Arrange for contact comfort and physical gratification. In your quest for sophisticated self-care, return again and again to the physical fundamentals.
5. Nurturing Relationships. Cultivate a support network at the office: Clinical colleagues, supervision groups, clinical teams, office staff, community professionals, and mentors. Equally important, secure nurturance away from the office: spouse/partner, family members (including pets), friends, spiritual advisors, and Colleague Assistance Programs. Ask yourself repeatedly, "Who has my back?" Expectedly, psychotherapists find healthy relationships both deeply satisfying and highly effective for self-care.
6. Setting Boundaries. Maintain boundaries (a) between self and others as well as (b) between professional life and personal life. During the day, schedule breaks, restrict caseload, refuse certain clients, insist on a livable income. Consider the 90 percent rule:

(*Continued*)

Table 22.1

(Continued)

only schedule up to 90 percent of desired hours to allow time for emergencies, family demands, and self-care. Balance client desires and self-preservation by saying "no" to patients, such as no shows, late cancellations, unpaid bills, and non-emergency intrusions in your life. Demarcate a boundary between work and public with a transition ritual.

7. Restructuring Cognitions. Monitor internal dialogue by your preferred method. Identify corrosive expectations about your performance as a clinician; for example, "I must be successful with my patients practically all of the time," "I should not have problems; after all, I am a psychologist!" Manage problematic countertransference reactions by self-insight, self-integration, empathy, anxiety management, and conceptualizing ability. Be gentle with yourself; shed the heavy burden of perfectionism that psychologists carry.
8. Sustaining Healthy Escapes. Beware the prevalent unhealthy escapes of substance abuse, isolation, and sexual acting out. Practice absorbing errands and healthy diversions away from the office, e.g., travel, hobbies, humor, relaxation, exercise. How do you play? Restore yourself with vital breaks, days off, personal retreats, vacations, and mini-sabbaticals.
9. Creating a Flourishing Environment. Harness the power of your work environment, thereby avoiding the fundamental attribution error (FAE) that your distress is solely your fault. Take an environmental audit of practice setting/office. Evaluate your work environment in terms of 6 key dimensions: work load, control, reward, sense of community, respect, and similar values. What is unsatisfactory and what can be done? High work demands plus high constraints is a toxic combination. Enhance the comfort of your work safety, privacy, lighting, ventilation, furniture, and aesthetics.
10. Undergoing Personal Therapy. Practice what you preach by seeking personal psychotherapy. Confront your resistances not to pursue personal treatment. Return to personal psychotherapy periodically throughout the lifespan without shame. Supplement psychotherapy with self-analysis. As an alternative, obtain an annual satisfaction checkup. Integrate with other forms of self-development, such as creative arts, meditation training, yoga.
11. Cultivating Spirituality and Mission. Reclaim your "mission" in life and in entering the profession. Cultivate wonder at the human spirit; it will enable you to pull hope from hell. Connect to the spiritual sources of your hope and optimism regarding behavior change. Confront squarely your own yearnings for a sense of transcendence and meaning. Become a citizen-therapist by merging your vocation with social activism. Let your life speak—manifest your core values in and outside the office.
12. Fostering Creativity and Growth. Strive for adaptiveness and openness to challenges—the defining characteristics of passionately committed psychologists. Involvement in diverse professional activities (e.g., psychotherapy, assessment, teaching, research, supervision) balances your workload and expresses the full array of skills. Attend clinical conferences, read literature, and form study groups to access the life springs of continued education. Expect a lifetime of struggle for awareness and growth; self-renewal is an ongoing process, not a CE workshop.

Adapted from *Leaving It at the Office: A Guide to Psychotherapist Self-Care.* © by John C. Norcross and James D. Guy. Adapted with permission of The Guilford Press.

As you traverse these strategies, we implore you to embrace self-care both at the office and away from the office. One way to *leave* distress at the office is to enhance functioning *at* that same office. Not to frantically squeeze 10 hours of work into 8 hours and then expect to retreat peacefully to a safe haven elsewhere, for instance. Another way to leave distress *at* the office is to enhance one's life *outside* the office: enjoying your relationships, participating in healthy escapes, renewing your spirituality, for instance, so that you are fully charged for the onslaught of intense contact with challenging clients. The upshot is that a balanced and comprehensive plan for your self-care will require a dual focus in your workplace and outside your workplace.

VALUE THE CHILD THERAPIST

Self-care begins with valuing the person of the therapist. We need to assess our own self-care and life satisfaction as we would a client's. Child and play therapists are highly trained and experienced change agents, and yet we often take little time in learning about how to cope with the hazards of our craft (Norcross & Guy, 2007).

Our clients count on us, rely on us, to be strong and emotionally available. They see us as the central path to their healing. Meta-analyses of psychotherapy outcomes consistently point toward the quality of the relationship between the therapist and client as the single most important ingredient in positive outcomes (Norcross, 2002). The therapeutic relationship rivals, if not exceeds, the proportion of outcome attributed to whatever treatment method is used (Wampold, 2001).

After clinicians practice for five or more years, they typically become more deeply satisfied with clinical work, perhaps reflecting a growing confidence that overrides the beginner's initial feelings of being a charlatan or fraud. By focusing on the successes and satisfactions inherent in the clinical work, we can overcome the feelings of disappointment and failure that also comes with the work. Recalling why we first entered the field, along with the multiple rewards of the work, helps to combat compassion fatigue. In fact, 93 percent of therapists polled rated the alleviation of client distress and promoting growth in the lives of others the greatest satisfactions (Kramen-Kahn & Hansen, 1998). Reflecting back on the times that we made a significant difference in the life of another person can renew us. Recalling client successes—pulling hope from hell—can bring us almost spiritual comfort during times of self-doubt and discouragement (Norcross & Guy, 2007).

LEARN FROM OUR CLIENTS

During such moments of discouragement, child therapists can learn from our clients and be inspired by their struggles, insights, and wisdom. Our clients encourage us, indirectly, to take risks, try new things, and take chances with them as they overcome obstacles in their life.

Clients are not the only ones changed by psychotherapy. We practitioners feel enriched, nourished, and privileged in conducting the work. The cumulative research shows clinical work enhances our sensitivity to the feelings of others, heightens our ability to tolerate the range of human emotions, accelerates our own emotional growth, and improves communication skills (Norcross & Guy, 2007). In the words of Ralph Waldo Emerson, ''It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself.''

ENHANCE THE WORK ENVIRONMENT

The self-care and burnout fields have historically been polarized into rival camps. One camp focuses on the individual's deficits—the ''fault, dear Brutus, is in ourselves'' advocates—and correspondingly recommends individualistic solutions to self-care. A second camp focuses on the systemic and organizational pressures—the ''impossible profession with inhumane demands'' advocates—and naturally recommends environmental and social solutions. We have learned to value both camps and adopt an interactional perspective that recognizes the reciprocal confluence of person-in-the-environment. The self is always in a system.

Avoid attributing occupational stress solely to individuals; it is part and parcel of the environment. We are not alone in our experience of compassion fatigue. Adopt a systemic perspective and normalize your reactions. Correspondingly, harness the power of your work environment (people, places, and things).

The greater the misfit between the job and ourselves, the greater the likelihood of stress (Maslach & Goldberg, 1998). Conversely, the greater the congruence or fit between your job and yourself, the greater the rewards and satisfaction.

We recommend an environmental audit to assess six factors associated with burnout (Leiter & Maslach, 2005) in your work environment:

- We are overworked (work overload)
- We lack control over what we do
- We are insufficiently rewarded for our work

- We are experiencing a breakdown in community
- We aren't treated fairly
- We're dealing with conflicting values

Then examine with your colleagues' potential corrections to these systemic drains. Clinical positions, particularly in institutional settings, will be necessarily demanding, but increasing support and decreasing constraints make the position manageable and rewarding.

Join with your peers to change the work atmosphere at an organizational and agency level in order to support self-care and reduce burnout.

Create Your Work Space

Conduct another environmental audit of your immediate workspace for comfort and appeal. Is it private, safe, comfortable, welcoming? Create a soothing work environment: soft colors, low lighting, cozy chairs, pleasant artwork, fish tank, and soothing music. All of these sustain both the client as well as the clinician. Include items that are signs of life and beauty in your work space, such as plants and flowers.

Give yourself time between clients, 10 minutes to breathe, take deep breaths and blow bubbles, relax, make notes, review notes, return calls and process what has happened in the previous session. Schedule time during the day or work week to get a massage to pamper yourself. Take time during the week to use play-based experiences. Draw, color, paint, or use a sandtray to let go of the stresses that linger from a session.

Secure Support and Supervision

Child therapists will invariably experience countertransferential feelings toward their clients and especially their parents/caretakers. Individual supervision, group consultation, or peer supervision can alleviate the blocked and frustrated feelings with clients.

Different types of difficulties or burnout call for different self-care strategies. Transient and time-limited difficulties require improving one's knowledge base, training, and wider experiences. On the other hand, difficulties that are situational will require tolerance, support, and acceptance, while difficulties that are systemic or interactional will require self-awareness and countertransference measures (Norcross & Guy, 2007).

One way to formalize nurturance from colleagues is through creating or joining a peer/support group that meets regularly for the purpose of discussing professional concerns. Peer groups are an inexpensive way to obtain a sense of community with other professionals, share difficult cases and feelings, learn about practice management, and receive the support of colleagues. Peer groups need to be carefully selected and structured to ensure trust and confidence. Feeling safe is paramount in order to allow for a trusting setting to share personal and professional stress.

An alternative is the creation of a Balint group, named after British psychoanalyst Michael Balint (1957). This type of group, while a form of peer consultation, differs in that there is an identifiable group leader. This leader facilitates the process and ensures that individual members are neither criticized nor challenged for their treatment decisions, which are shared. The purpose is not to find solutions, offer advice, or present formal cases, but rather to help increase understanding of the client's disorder and to offer divergent views on how the therapist responded to the client.

Clinical supervision can be a helpful way of closely looking at personal roadblocks, such as recurrent themes in difficult cases, who the client reminds us of, and how stressful clients leave us feeling. It can be a safe haven for review of problem cases, ethical dilemmas, evidence-based practices, transference and countertransference, and case management.

SEEK NOURISHING RELATIONSHIPS

At the start of his novel, *Howard's End,* E. M. Forster implores us to ''only connect.'' It is a thoughtful prescription to secure nourishing relationships to keep us in touch with inner feelings, needs, and longings that are set aside during a day of seeing clients. Partners affirm our worth and dignity. We need to give ourselves permission to be cared for, loved, and nurtured. Also, reach out and tell colleagues and family members what kind of emotional support you need from them at that moment. Research affirms that the largest determinant of happiness is having a supportive network of close relationships (Myers, 2000). A variety of relationships outside of the office allow for a balanced and satisfying life. Zealously protect your personal time with family and friends.

Keep home as home and work as work! Avoid blurring life outside the office with professional work, such as thinking of social events as attending workshops, conferences, or conventions, and attending supervision or book discussion groups that focus on therapy. Don't allow social gatherings at work to become meetings or discussion times about work. Work colleagues should not become the primary or only friends we have (Norcross & Guy, 2007).

Set Boundaries

Boundary is a limit or territory that is not to be violated. In clinical work, boundary carries at least three meanings: between self and other; between professional and personal life; and between effective or ethical and ineffective or unethical. In each instance, the goal is to set clear yet flexible boundaries. Such boundaries lead to reduced stress and less fusion with distressed children and distressing work environments (Norcross & Guy, 2007).

Leave work *at* work! Develop a transition ritual for leaving work to help mentally and emotionally signal the end of your work day. Try taking a few minutes to blow bubbles and do deep breathing. Or play some music for a few minutes as you get ready to leave. Create a mental and physical signal that you are leaving the work behind.

Research shows that setting boundaries consistently emerges as one of the most frequently used and one of the most highly effective self-care principles (Norcross & Guy, 2007). Sherman and Thelen (1998) found that 72 percent of psychotherapists schedule breaks during the day, 59 percent kept their caseload at a specific level, and 56 percent refused certain types of clients. In order to do this we need to recognize our personal strengths and limitations. The therapist who understands her role, as defined by theoretical orientation and personal style, will have an easier time communicating her personal and professional boundaries to clients (Norcross & Guy, 2007).

In that vein, practice child and family therapy as a collaborative process with mutual responsibilities. Active collaboration sets boundaries and reinforces shared responsibilities for the change process and treatment outcomes. This partnership is anchored to the belief that the client can improve, the process of psychotherapy indeed works, and the outcome will make all of the effort worthwhile. We cannot neurotically assume responsibility for clients' disorders or healing, but we can travel on the journey with them toward healing.

Set realistic expectations for yourself and your clients. Recognize your limitations and the reality that all therapists will make mistakes (Meichenbaum, 2005). Accept that there are some things we simply cannot fix. Minimize self-blame and blame in others, and focus on finding meaning and hope by looking for the signs of resilience. Adopt a more philosophical or spiritual outlook in accepting those things that you cannot change, working on those aspects that are potentially changeable, and knowing the difference.

Recognize Limits

Saying no can be difficult. Saying no to patients—for no shows, late cancellations, unpaid bills, nonemergency calls—is even tougher for most child therapists. Yet, it is a matter of integrity to say no and honor our limits. Avoid the heartache of practicing in ways we do not believe and in ways that undermine our ethics, all of which adds stress and can compromise client care.

Know and implement limits, either in saying no to unreasonable requests, in getting training, obtaining supervision, or in transferring a case. Consider transferring a case if there is a poor client-therapist match, there is a shaky therapeutic alliance, when the client's life circumstances are too close to those of the therapist's, or when the case is outside of our competence. Transferring a client is not a sign of failure (Norcross & Guy, 2007).

CREATE VARIETY IN WORK

Creativity is unleashed when we diversify. Here we mean diversity in several distinct senses: diversifying your clinical work; diversifying your clients; and diversifying your professional activities. The research indicates that such diversification is a protective factor against burnout (Skovholt & Jennings, 2004).

Diversifying your clinical work essentially means to mix it up. Rearrange your clinical schedule (different parts of day, for example), alter your activities, offer different methods (play therapy, psychoeducation, skills training, for example), consider diverse therapy formats (individual, family, group), move the furniture, switch some pictures. We are all at risk of becoming stale.

Diversify your child clients in terms of their characteristics and concerns. Practicing within their clinical competence, of course, practitioners are rewarded with the spice of life by working with patients of a variety of ages, genders, ethnicities, faiths, socioeconomic classes, and diagnostic clusters. Anyone who has seen five straight externalizing boys in a row knows exactly of what we speak. Anyone but another oppositional defiant or conduct disorder! Far better for the practitioner—and probably for the patient—to intersperse with patients presenting with anxiety, internalizing, or mood disorders.

In extrapolating from the empirical research on psychotherapists' self-care, we discern a recurring theme: the diversity and synergy of professional activities. The diversity is grounded in performing multiple activities—psychotherapy, assessment, research/writing, teaching, clinical supervision, consultation, and administration. In a study on clinical psychologists (Norcross, Karpiak, & Santoro, 2005), we found that half or more of them were routinely involved in all eight of the preceding professional activities.

One of the many benefits of being a psychotherapist is our degrees of freedom. We can write a book, teach others, offer community outreach, consult with agencies and self-help organizations, perform executive coaching, supervise interns, conduct research, lead parenting seminars, evaluate programs, provide divorce mediation, ad infinitum. Multiple benefits accrue from these multiple role functions: Our career fulfillment, skill sets, and clinical impact generally increase.

CHECK YOUR THINKING

Self-monitor your internal dialogue to recognize cognitive errors or faulty assumptions and figure out alternatives. Take your emotional temperature (Meichenbaum, 2005) as a way of self-monitoring.

Over the years Albert Ellis (1984) gathered the common irrationalities or lies we psychotherapists tell ourselves. His list of five ''musturbations''—things that many therapists tell themselves they must do—are extracted from his ''How to Deal with Your Most Difficult Client—You'':

- I must be successful with my patients, practically all of the time.
- I must be one of the world's most outstanding therapists.
- I should have no problems. After all, I am a therapist!
- I must be liked and respected by all my clients. Since I am a hard-working therapist, my clients should be equally persevering.

Regarding the first musturbation, pay attention to the feeling that you must always have a brilliant empathic response or that you must not fail with any of your clients, and if you do it is your fault. Rejoice in your successes, and accept your human limitations. Offer *yourself* unconditional acceptance. We forget that it is only 5–15 percent of clients that experience increased distress and deterioration while in psychotherapy (though not necessarily the result of psychotherapy), and 75 percent or more are successes. We tend to preoccupy ourselves with the failures. Tracking or keeping a journal of your successes can keep in balance and remind you of your successes. We do make a difference in our clients' lives.

We may tend to believe that if a client succeeds in therapy, it is her responsibility, but if a client fails in therapy, it is our fault! Be gentle with yourself. Remember, your life is a work in progress! Freud (1937/1964, p. 247) aptly stated ''Analysts are people who have learned to practice a particular art; alongside of this, they may be allowed to be human beings like anyone.''

TAKE A BREAK

We need to take and relish breaks during our work, not see them as a waste of time any more than needing to stop and gas up the car. Taking breaks is necessary and beneficial, resulting in increases in time and energy. We need periodic relaxation during the workday, not just after the workday. Schedule mini-breaks between sessions to stretch your muscles and reconnect to your body, utilize brief meditations, guided imagery, deep breathing, and muscle relaxation. Self-massage your face, neck, and leg muscles. Use things that will help reduce autonomic and mental frenzy, such as music, imagery, and replenishing scents. Be sure you get sufficient hydration during the day, and insist on sufficient time alone.

Replenishing breaks also apply away from the office. We all require a Shabbat—a regularly scheduled day of rest and respite from the week's demands. Take some mental health time to get away for a day, weekend, or more. Give yourself permission to take time off and escape when necessary. Do you know how to spend your time off when it's available?

LAUGH AND PLAY

Retaining and using your sense of humor helps alleviate stress and counters frustration. The research shows that humor in psychotherapy is decidedly beneficial (Cann, Holt, & Calhoun, 1999; Goldin & Bordin, 1999; Nezu, Martin, 2001; Nezu, & Blissett, 1988) in reducing tension, discharging energy, lifting mood, providing intellectual stimulation, putting events in perspective, stimulating creative thinking, expressing exuberance and warmth, and creating a bond between those sharing the joke. Something so small as laughter can bring so much. ''A therapist's sense of humor is a reflection of her joyfulness, passion, creativity and playfulness'' (Norcross & Guy, 2007, p. 138).

Which brings us to the centrality of play in therapist's self-care repertoire. Play by itself has many healing powers (Schaefer, 1999) and therapeutic benefits. But how do you find time to play? How do you step away from a busy life, have fun, and find renewal? About three-quarters of therapists find play in a multitude of ways impossible to catalog. They play as hard as they work at every imaginable activity: painting, writing, singing, dancing, fishing, watching movies, exercising, and even performing as clowns at parties! Hobbies are self-nourishing, playful escapes from work and into our passions (Norcross & Guy, 2007).

These nonrational and creative pursuits counterbalance the typically serious and rational nature of conducting psychotherapy. Such pursuits free the therapist from the burdensome compulsion of attempting to understand patients and solve problems (Boylin & Briggie, 1987).

One way to remain playful is to go back to and reexperience favorite childhood activities: amusement rides, water slides, water-gun fights, hide and seek, blowing bubbles, catching fireflies, playing horseshoes, building structures out of clay or dirt, running through the pouring rain, jumping in mud puddles, playing board games—especially the ones that include acting, drawing, or building. Dance around the living room, and sing in the car. The possibilities are, quite literally, limitless.

And Grow

What distinguishes the passionately committed psychotherapist from the run-of-the-mill therapist? Adaptiveness and openness to challenges (Dlugos & Friedlander, 2001). Passionately committed therapists score quite high on psychometric measures of openness—seeking new knowledge, availing oneself to new experiences, and appreciating ordinary experiences as potentially extraordinary. Moreover, passionate therapists transform obstacles into challenges. A case in point is working with seriously disturbed children: Passionate therapists move heaven and earth in coordinating premier care and in providing exceptional service despite the odds.

The ultimate self-care strategy is to grow—not merely to survive, but to thrive (Pope & Vasquez, 2007). Continued growth emerges as one of the highest ranked occupational rewards and one of the highest rated career-sustaining behaviors of psychotherapists (Kramen-Kahn & Hansen, 1998). It might be personal readings, exciting workshops, journal clubs, mentoring, forming a study group, at home study, or new training opportunities. Whatever it is, it should set your hair on fire—*kaizen*—that actualizes your love of lifelong learning.

Jim Bugental (1987, p. 95) reminds us: ''An art is not a contest; it's a continual growing. Whenever the artist thinks she's mastered the craft, she's stopped growing and so has stopped being an artist. True art is only found on the edge of what is unknown—a dangerous place to be, an exciting place to work, a continually unsettling place to live subjectively.''

IN CLOSING

> To put the world right in order, we must first put the nation in order; to put the nation in order, we must first put the family in order; to put the family in order, we must first cultivate our personal life; we must first set our hearts right.
>
> —Confucius

Self-care is a personal challenge and ethical imperative that every child therapist—literally, every one—must consciously confront. We can effectively avail ourselves of multiple self-care strategies unencumbered by theoretical dictates tailored to our unique resources, vulnerabilities, and environments. Be broad, flexible, and context sensitive in replenishing yourself. And expect a lifetime of struggling for awareness and pursuing growth. Self-care is not a list one checks off in the morning; rather, it is a skillful attitude and lifelong commitment.

The skillful commitment begins with making self-care a priority. You should never, ever, apologize for taking care of yourself! Too many of us treat it like a narcissistic luxury to be fulfilled as time permits; it is a human requisite, a clinical necessity, and an ethical imperative (Norcross & Guy, 2007). As clinicians we need to prioritize self-care by scheduling it, tracking it, and making sure we do it.

In closing, our fundamental point is to do something to transform awareness (or insight) into action. In C. S. Lewis's *The Screwtape Letters,* a demon imparts the following advice for capturing souls for Hell to his apprentice:

> The great thing is to prevent his doing anything. As long as he does not convert it into action, it does not matter how much he thinks about his new repentance. . . . Let him do anything but act. The more often he feels without acting, the less he will ever be able to act, and, in the long run, the less he will be able to feel.

So as you cultivate a skillful attitude for self-care, please translate the creative attitude into behavior, the commitment into corrective activity (lest your soul be lost to the demons!). You—and your clients—deserve no less.

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Epilogue

We have come to the culmination of this book. Hopefully the reader has found that it addressed many needs, added to personal knowledge and skill development, and presented a greater awareness of the benefits of play, play therapy, and play-based strategies which can be and are effectively blended with cognitive behavioral therapy, in the treatment of children and adolescents. Hopefully you, the reader, have come to the conclusion that the two worlds are not so far apart and blend well together.

With 22 chapters and almost 40 contributors this book is a rich compendium covering theory, treatment, technique, understanding of research, and self-care. It is my hope that the reader will come away with a much broader understanding, awareness, and practical use of play therapy, as well as an appreciation for the range of treatment approaches that currently do blend together both play therapy and cognitive behavioral therapy. Hopefully old biases and misconceptions have dissolved, and that this has become the start of a more collaborative and integrated approach in the research and treatment of children and adolescents.

APPENDIX

Books with Play-Based Techniques for Use with Children in Directive and CBT Sessions

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ISBN 978-0-470-17640-5
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9 780470 176405

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